Medicare Managed Care Manual

Chapter 13 - Medicare+Choice Beneficiary Grievances, Organization Determinations, and Appeals

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10 - Medicare+Choice (M+C) Beneficiary Grievances, Organization Determinations, and Appeals

(Rev. 22, 05-09-03)

This chapter deals with organization determinations and appeals for beneficiaries enrolled in a plan provided by a Medicare+Choice (M+C) organization and with any other complaints the enrollee may have with the M+C organization and any of the plans it offers. Noncontracted providers may have appeal rights in limited circumstances. For current Medicare plans that are converting to M+C organizations, these instructions supersede previous related instructions concerning appeal procedures for Medicare contracting health plans. Managed care organizations that are not converting to M+C organizations should continue to follow instructions previously set forth in the HMO/CMP Manual.

10.1 - Definition of Terms

(Rev. 22, 05-09-03)

Unless otherwise stated in this Chapter, the following definitions apply:

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the M+C organization and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Departmental Appeals Board (DAB), and judicial review.

Assignee: A physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service.

Authorized Representative: Any individual authorized by an enrollee, or a surrogate who is acting in accordance with state law on behalf of the enrollee, in order to obtain an organization determination or deal with any level of the appeals process. Representatives are subject to the rules described in 20 CFR Part 404, Subpart R, unless otherwise stated in this chapter of the manual.

Complaint: Any expression of dissatisfaction to an M+C organization, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers, insurers, or M+C organizations such as: Waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes the organizations' refusal to provide services the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint

could include both. Every complaint must be handled under the appropriate grievance or appeal process.

Effectuation: Compliance with a reversal of the M+C organizations' original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Enrollee: An M+C eligible individual who has elected an M+C plan offered by an M+C organization, or his/her authorized representative.

Grievance: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which an M+C organization or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee may make the complaint or dispute, either orally or in writing, to an M+C organization, provider, or facility. A grievance may also include a complaint that an M+C organization refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration timeframes.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Independent Review Entity: An independent entity contracted by CMS to review M+C organizations' denial of coverage determinations.

Inquiry: Any oral or written request to an M+C organization, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee.

Organization Determination: Any decision made by or on behalf of a M+C organization regarding payment or services to which an enrollee believes he or she is entitled.

Quality Improvement Organization (QIO): Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. They review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. The QIOs also review continued stay denials in acute inpatient hospital facilities.

Quality of Care Issue: A quality of care issue may be filed through the M+C organization's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by an M+C organization meets professionally recognized standards of health care, including whether

appropriate health care services have not been provided or have been provided in inappropriate settings.

Reconsideration: An enrollee's first step in the appeal process; an M+C organization or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

10.2 - Responsibilities of the M+C Organization

(Rev. 22, 05-09-03)

Each M+C organization and each M+C plan that it offers must establish and maintain procedures for:

1. Standard and expedited organization determinations;

2. Standard and expedited appeals; and

3. Grievances.

M+C organizations also must provide written information to enrollees about the grievance and appeal procedures that are available to them through the M+C organization, at the following times:

1. Grievance procedure - at initial enrollment, upon involuntary disenrollment initiated by the M+C organization, upon denial of an enrollees' request for expedited review, upon an enrollees request, and annually thereafter;

2. Appeal procedure, including the right to expedited review - at initial enrollment, upon notification of an adverse organization determination or denial, and annually thereafter.

3. Quality of care complaint process available under QIO process as described in §1154(a)(14) of the Social Security Act (the Act) - at initial enrollment, and annually thereafter.

As with all contractual responsibilities in the M+C program, the organization may delegate any of its grievances, organization determinations, and/or appeals responsibilities to another entity or individual that provides or arranges health care services. In cases of delegation, the M+C organization remains responsible and must therefore ensure that requirements are met completely by its delegated entity and/or individual.

10.3 - Rights of M+C Enrollees

(Rev. 22, 05-09-03)

Relative to grievances and appeals, the rights of M+C enrollees include, but are not limited to, the following:

10.3.1 - Grievances

(Rev. 22, 05-09-03)

1. The right to have grievances heard and resolved in accordance with the guidelines that are described in this chapter of the manual; and

2. The right to request quality of care grievance data from M+C organizations.

10.3.2 - Organization Determinations

(Rev. 22, 05-09-03)

1. The right to a timely organization determination;

2. The right to request an expedited organization determination as described in this chapter;

3. The right to receive information from a practitioner regarding the enrollee's ability to obtain a detailed written notice from the M+C organization regarding the enrollee's services; and

4. The right to a detailed written notice of an M+C organization's decision to deny, terminate or reduce a service in whole or in part, which includes the enrollee's appeal rights.

10.3.3 - Appeals

(Rev. 22, 05-09-03)

1. The right to request an expedited reconsideration as provided in this chapter;

2. The right to request and receive appeal data from M+C organizations;

3. The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE);

4. The right to automatic reconsideration by an IRE contracted by CMS, when the M+C organization upholds its original adverse determination in whole or in part;

5. The right to an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy is $100 or more;

6. The right to request Departmental Appeals Board (DAB) review if the ALJ hearing decision is unfavorable to the enrollee in whole or in part;

7. The right to judicial review of the hearing decision if the ALJ hearing and/or DAB review is unfavorable to the enrollee in whole or in part and the amount remaining in controversy is $1000 or more;

8. The right to make a quality of care complaint under the QIO process;

9. The right to request a QIO review of a determination of noncoverage of inpatient hospital care;

   If an enrollee receives immediate QIO review of a determination of noncoverage of inpatient hospital care, the above rights are limited. In this case, the enrollee is not entitled to the additional review of the issue by the M+C organization. The QIO review decision is subject to an ALJ hearing if the amount in controversy is at least $200.00 and review of an ALJ hearing decision or dismissal from the Departmental Appeals Board if $2,000.00 or more is in controversy. Enrollees may submit requests for QIO review of determinations of noncoverage of inpatient hospital care in accordance with the procedures set forth in §160.

10. The right to request and be given timely access to the enrollee's case file and a copy of that case subject to Federal and state law regarding confidentiality of patient information. The M+C organization shall have the right to charge the enrollee a reasonable amount, for example, the costs of mailing and/or an amount comparable to the charges established by a QIO for duplicating the case file material. At the time the request for case file material is made, the M+C organization should inform the enrollee of the per page duplicating cost. Based on the extent of the case file material requested, the M+C organization should provide an estimate of the total duplicating cost for which the enrollee will be responsible. The M+C organization may also charge the enrollee the cost of mailing the material to the address specified. If enrollee case files are stored offsite, then the M+C organization may not charge the enrollee an additional cost for courier delivery to a plan location that would be over and above the cost of mailing the material to the enrollee.

11. The right to challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or

Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The new coverage challenge process will be available to both beneficiaries with original Medicare and those enrolled in Medicare managed care plans.

The CMS is in the process of developing regulations to implement the new Medicare challenge process required under §1869 of the Act. Notice and comment rulemaking will ensure that all interested parties, including M+C organizations, have an opportunity to express their views concerning the proposed procedures and raise questions about their related responsibilities. We will issue guidance on the new process to the M+C organizations after rulemaking is completed. M+C organizations have no obligations with respect to the new coverage process at this time.

20 - Complaints

(Rev. 22, 05-09-03)

20.1 - Complaints That Apply to Both Appeals and Grievances

(Rev. 22, 05-09-03)

Complaints may include both grievances and appeals. Complaints can be processed under the appeal procedures, under the grievance procedures, or both depending on the extent to which the issues wholly or partially contain elements that are organization determinations. One complaint letter may contain a grievable issue and an appealable issue. If an enrollee addresses two or more issues in one complaint, then each issue should be processed separately and simultaneously (to the extent possible) under the proper procedure.

20.2 - Distinguishing Between Appeals and Grievances

(Rev. 22, 05-09-03)

Appeal procedures are to be used for complaints or disputes involving organization determinations. Grievance procedures are separate and distinct from organization determination and appeal procedures. Determine whether the issues in an enrollee's complaint meet the definition of a grievance, an appeal, or both. The M+C organization then must resolve all enrollee's complaints or disputes through the appropriate procedure to meet the particular type of complaint.

For example, M+C organizations must determine whether to categorize complaints about copayments on a case-by-case basis. M+C organizations must subject complaints about copayments to the appeals process when an enrollee believes that an M+C organization has required the enrollee to pay an amount for a health service that should be the M+C organization's responsibility. If an enrollee expresses general dissatisfaction about a

copayment amount, then an M+C organization should process the enrollee's complaint as a grievance.

Complaints concerning an enrollee's involuntary disenrollment initiated by the M+C organization must also be processed through the grievance procedures. Other types of complaints that might fall into the grievance category include, but are not limited to: A change in premiums or cost sharing arrangements from one contract year to the next, Difficulty getting through on the telephone, The quality of care or services provided, Interpersonal aspects of care, such as rudeness by a provider or staff member, or failure to respect an enrollee's rights.

The facts surrounding a complaint will determine whether the appeals or grievance process should be initiated. The following are offered as examples of when each process should begin:

- An enrollee who currently takes a particular brand-name drug is dismayed to find out that the plan has made a formulary change and will no longer cover the drug used by the enrollee. The enrollee calls the plan and complains. The enrollee states that he/she has tried the generic equivalent before and it was not effective, and therefore wants the plan to continue coverage of the brand-name drug. This complaint should be treated as a request for an organization determination, subject to the appeals process, on continuation of coverage for the brand-name drug.

- An enrollee who currently does not take any prescription medications reads in his annual notice of change that the plan will no longer be covering any brand-name drugs. The enrollee calls the plan to complain about this reduction in benefits, even though it does not directly affect them at the current time. Because the enrollee does not take any prescription medications, the complaint cannot be interpreted as a request for an organization determination. The complaint should therefore be handled as a grievance.

Complaints concerning the quality of medical care received under Medicare may be acted upon by the M+C organization, but also may be addressed through the QIO complaint process under §1154(a)(14) of the Act. (See also the QIO Manual chapter regarding the Beneficiary Complaint Process.) This process is separate and distinct from the M+C organization's grievance process. For example, if an enrollee believes his/her physician misdiagnosed the enrollee's condition, then the enrollee may file a complaint with the QIO in addition or in lieu of a complaint filed under the M+C organizations' grievance process.

Complaints concerning organization determinations are resolved through appeal procedures. Organization determinations primarily include complaints concerning the benefits to which an enrollee is, or believes he/she is, entitled, i.e., payment or provision of services. Additionally, an appeal might arise from a complaint when an enrollee disputes the calculation of his/her copayment amount.

At times M+C organizations will need to process complaints using the M+C organization's grievance procedures as well as its appeal procedures. For example, an enrollee might complain that because he/she had to wait so long to obtain a referral, he/she received services out of network. The enrollee's complaint contains both an appealable request for payment as well as a grievance about the timeliness of services. Therefore, complaints must be reviewed on a case-by-case basis.

20.3 - Procedures for Handling a Grievance

(Rev. 22, 05-09-03)

Each M+C organization, under any M+C plan that it offers, must provide meaningful procedures for timely hearing and resolving grievances between enrollees and the M+C organization or any other entity or individual through which the M+C organization provides health care services.

Until such time as additional requirements are established as part of formal rulemaking, the M+C organization must continue to include the following requirements in its grievance procedures:

1. Ability to accept any information or evidence concerning the grievance;

2. Timely transmission of grievances to appropriate decision-making levels in the organization;

3. Prompt, appropriate action, including a full investigation of the complaint if necessary; and

4. Notification of investigation results to all concerned parties, consistent with state law.

20.3.1 - Procedures for Handling Misclassified Grievances

(Rev. 22, 05-09-03)

Should an M+C organization misclassify a grievance as an appeal and issue a denial notice and if the independent review entity determines that the complaint was misclassified as an appeal, then the independent review entity must dismiss the appeal and return the complaint to the M+C organization for proper processing. The M+C organization must notify the enrollee in writing that the complaint was misclassified and will be handled through the M+C organization's grievance process. M+C organizations are expected to audit their own appeals and grievance systems for the presence of errors, and institute appropriate quality improvement projects as needed.

EXAMPLE

An M+C organization enrollee has a contractual benefit that covers one pair of eyeglasses every 24 months with a maximum M+C organization contribution of $70.00. The enrollee ordered glasses as prescribed by an M+C organization optometrist and was covered for $70.00 of the bill. The enrollee returned to the optometrist, asserting that the glasses were no good and the prescription was wrong. The enrollee requested M+C organization coverage for another pair of glasses. Where an enrollee complains that contractually covered and previously rendered services are inadequate or substandard in quality, this type of complaint (i.e., request for another pair of glasses) should be classified as a grievance (quality of care complaint) as opposed to an appeal.

20.4 - Written Explanation of Grievance Procedures

(Rev. 22, 05-09-03)

The M+C organization must provide all members with written grievance procedures upon initial enrollment, involuntary disenrollment (i.e., initiated by the M+C organization), upon denial of an enrollee's request for expedited review, annually, and upon request. The Evidence of Coverage (EOC) must clearly explain the grievance procedures. Additionally, the M+C organization must notify enrollees about any changes to its grievance procedures 30 days in advance of the effective date of the change. The notice must include at least the following information:

1. How and where to file a grievance; and

2. The differences between appeals and grievances.

30 - Organization Determinations

(Rev. 22, 05-09-03)

An organization determination is any determination (i.e., an approval or denial) made by the M+C organization, or its delegated entity with respect to the following:

1. Payment for temporarily out of the area renal dialysis services;

2. Payment for emergency services, post-stabilization care, or urgently needed services;

3. Payment for any other health services furnished by a provider (other than the M+C organization), that the enrollee believes:

    i. Are covered under Medicare, or

    ii. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the M+C organization;

4. Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the enrollee believes should be furnished or arranged by the organization;

5. Discontinuation of a service that the enrollee believes should be continued because they believe the service to be medically necessary, in accordance with this chapter; and

6. Failure of the M+C organization to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Each M+C organization must establish procedures for making timely organization determinations regarding the benefits an enrollee is entitled to receive under an M+C plan. It includes basic benefits, mandatory and optional supplemental benefits and the amount, if any, that the enrollee is required to pay for a health service.

Once an "organization determination" has occurred, the appeals process may be triggered if an enrollee believes the M+C organization's decision is unfavorable. If an M+C enrollee disputes an organization determination, the case must be handled using the federally mandated appeals process. If an enrollee complains about any other aspect of the M+C organization (e.g. the manner in which care was provided), the M+C organization must address the issue through the separate grievance process.

When the M+C organization decides not to provide or pay for a requested service, in whole or in part, this decision constitutes an adverse organization determination. In the presence of any adverse organization determination, an M+C organization must provide the enrollee with a written denial notice with appeal rights. See Appendix 1.

M+C organizations must ensure issuance of written notices of adverse organization determinations whenever coverage is denied. Providers must be educated that they must inform enrollees that a request for a denial notice must be submitted to the M+C organization if the enrollee believes that the enrollee is being denied a service. Once the determination is made, the M+C organization must issue the denial notice (see also §40.2.1).

30.1 - Procedures for Handling Misclassified Organization Determinations

(Rev. 22, 05-09-03)

All organization determinations are subject to appeal procedures. Sometimes complaints do not appear to involve organization determinations and are misclassified as grievances exclusively. This may occur because the organization did not issue the written notice of an adverse organization determination (i.e., a denial notice). Upon discovery of such an error, the M+C organization must notify the enrollee in writing that the complaint was

misclassified and will be handled through the appeals process. The timeframe for processing the complaint begins on the date the complaint is received by the M+C organization, as opposed to the date the M+C organization discovers its error. M+C organizations are expected to audit their own appeals and grievance systems for the presence of errors and institute appropriate quality improvement projects as needed.

30.1.1 - Quality of Care

(Rev. 22, 05-09-03)

A complaint received by an M+C organization concerning the quality of service a member received is generally treated as a grievance. However, quality of care complaints are occasionally complaints of a denial of services. For example, a member complains of poor medical care because his/her doctor did not authorize a surgery or other medical service. This complaint involves a denial of service that should simultaneously be processed through the appeal procedures of the plan. In this case, the M+C organization is responsible for directing the complaint to the appeal process and the grievance process.

Complaints about quality of care issues may also be received and acted upon by the QIO. In situations in which the enrollee has gone both to the QIO and to the M+C organization, M+C organizations must recognize the authority of the QIO with respect to timely submission of requested information/documentation.

30.1.2 - Service Accessibility

(Rev. 22, 05-09-03)

Complaints concerning the timely receipt of services that have already been provided may be treated as grievances. However, when a member complains that he/she has been unable to obtain a service that he/she believes they are entitled to receive (such that a delay would adversely affect the health of the enrollee), it should be addressed as an organization determination, which can then be appealed.

When the member complains that he/she had to wait so long for a service that he/she went out-of-plan, the complaint should be treated as an appeal for payment for the out-of-plan services as well as a grievance about the timeliness of the service.

30.1.3 - Employer-Sponsored Benefits

(Rev. 22, 05-09-03)

M+C appeal procedures apply to all benefits offered under an M+C organization - including optional supplemental benefits. However, determinations on items or services purchased by an employer, over and above the Medicare approved benefit package provided by the M+C organization, such as payments of premiums or beneficiary cost sharing provided by the employer, are not subject to these M+C guidelines.

30.2 - Jurisdiction for Claims Processed on Behalf of M+C Enrollees Through the Original Medicare-Fee-For-Service (FFS) System

(Rev. 22, 05-09-03)

Claims received by Medicare fee-for-service (FFS) carriers for enrollees of M+C organizations will be denied, and the supplier, physician or practitioner will be notified through the claim level remittance advice reason code message 109 that the services should be billed to the patient's managed care plan.

Claims received by Medicare FFS fiscal intermediaries (FIs) for enrollees of M+C organizations will be transferred to the member's M+C organization for processing. This transfer is not considered a denial on the part of the FI. As a result, the M+C member has no appeal rights under the Medicare FFS program. If the M+C organization denies the claim, the M+C organization must issue its member a denial notice with appeal rights. The M+C organization has jurisdiction for this claim.

40 - Standard Organization Determinations

(Rev. 22, 05-09-03)

40.1 - Standard Timeframes for Organization Determinations

(Rev. 22, 05-09-03)

When an enrollee has made a request for a service, the M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination.

The M+C organization may extend the timeframe up to 14 calendar days. This extension is allowed to occur if the enrollee requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). When the M+C organization grants itself an extension to the deadline, it must notify the enrollee, in writing, of the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization must notify the enrollee, in writing, of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of any extension that occurs, in accordance with this chapter.

The M+C organization must pay 95 percent of clean claims from noncontracted providers within 30 calendar days of the request. All other claims must be paid or denied within 60 calendar days from the date of the request.

40.2 - Notice Requirements for Standard Organization Determinations

(Rev. 22, 05-09-03)

40.2.1 - Written Notification by Practitioners

(Rev. 22, 05-09-03)

The M+C organization must educate practitioners that there may be situations where an enrollee disagrees with a practitioner's decision about a request for a service or a course of treatment. Thus, at each patient encounter with an M+C enrollee, a practitioner must notify the enrollee of his or her right to receive, upon request, a detailed written notice from the M+C organization regarding the enrollee's services. The practitioner's notification must provide the enrollee with information about how to contact the M+C organization. Given that practitioners may contract with one or more M+C organizations, M+C organizations are encouraged to allow their practitioners discretion for how best to incorporate such notification into their existing practices.

40.2.2 - Written Notification by M+C Organizations

(Rev. 22, 05-09-03)

If an enrollee requests an M+C organization to provide a detailed notice of a practitioner's decision to deny a service, in whole or in part, or if the M+C organization decides to deny, in whole or in part, the services or payments then it must give the enrollee a written notice of its determination. If the beneficiary has a representative, the representative must be sent a copy of the notice.

The M+C organization must use approved notice language in Appendix 1. As an alternative, M+C organizations that use electronic EOBs may continue to use the EOB with the standard appeals language on the back in lieu of the standardized Notice of Denial of Payment (NDP). The standardized denial notice forms have been written in a manner that is understandable to the enrollee and provides:

1. The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;

2. Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf (as mandated by 42 CFR 422.570 and 422.566(b)(3);

3. For service denials, a description of both the standard and expedited reconsideration processes and timeframes, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;

4. For payment denials, a description of the standard reconsideration process and timeframes, and the rest of the appeals process; and

5. The beneficiary's right to submit additional evidence in writing or in person.

Example of language that is not acceptable in §40.2.2, list item 1, above (because it is not specific enough or understandable):

> You required skilled rehabilitation services-P.T. eval. for mobility + gait-eval. for ADL's, speech eval. swallowing - from 6/5/2001, and these services are no longer needed on a daily basis.

The denial rationale must be specific to each individual case and written in a manner calculated for an enrollee to understand.

Examples of language that is acceptable (because it is specific to the individual's case):

> The case file indicated that while Jane Doe was making progress in her therapy programs, her condition had stabilized and further daily skilled services were no longer indicated. The physical therapy notes indicate that she reached her maximum potential in therapy. She had progressed to minimum assistance for bed mobility, moderate assistance with transfers, and was ambulating to 100 feet with a walker. The speech therapist noted that her speech was much improved by 6/12/2001, and that her private caregiver had been instructed on safe swallowing procedures and will continue with feeding responsibilities.
>
> Home health care must meet Medicare guidelines, which require that you must be confined to your home. You are not homebound and consequently the home health services requested are not payable by Medicare or the M+C organization.
>
> Golf carts do not qualify as durable medical equipment as defined under Medicare guidelines. Medicare defines durable medical equipment as an item determined to be necessary on the basis of a medical or physical condition, is used in the home or an institutional setting, and meets Medicare's safety requirements. A golf cart does not meet these requirements and is not payable by Medicare or (**name of health plan**).

40.2.3 - Notice Requirements for Noncontracted Providers

(Rev. 22, 05-09-03)

If the M+C organization denies a request for payment from a noncontracted provider, the M+C organization must notify the noncontracted provider of the specific reason for the denial and provide a description of the appeals process. The M+C organization must also explain that in the event that the noncontracted provider wishes to appeal, the noncontracted provider must sign a waiver of liability statement. See Appendix 6.

40.3 - Effect of Failure to Provide Timely Notice

(Rev. 22, 05-09-03)

If the M+C organization fails to provide the enrollee with timely notice of an organization determination, this failure itself constitutes an adverse organization determination and may be appealed. The M+C organization must include in the annual Evidence of Coverage (EOC) information regarding an enrollee's right to appeal when the M+C organization fails to provide a timely notice.

50 - Expedited Organization Determinations

(Rev. 22, 05-09-03)

An enrollee, or any physician (regardless of whether the physician is affiliated with the M+C organization), may request that an M+C organization expedite an organization determination when:

1. The enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy; and

2. The enrollee believes the M+C organization should furnish directly or arrange for services to be provided (when the enrollee has not already received the services outside the M+C organization).

Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received. However, if a case includes both a payment denial and a pre-service denial, the enrollee has a right to request an expedited appeal for the pre-service denial.

50.1 - Making a Request for an Expedited Organization Determination

(Rev. 22, 05-09-03)

When asking for an expedited organization determination, the enrollee or a physician must submit either an oral or written request directly to the organization, or if applicable, to the entity responsible for making the determination. A physician may also provide oral or written support for an enrollee's own request for an expedited determination.

1. The M+C organization must automatically provide an expedited organization determination to any request made or supported by a physician. The physician must indicate, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The physician need not be appointed as the enrollee's authorized representative in order to make the request.

2. For a request made by an enrollee, the M+C organization must expedite the review of a determination if the organization finds that the enrollee's health, life, or ability to regain maximum function may be jeopardized by waiting for a standard organization determination.

3. If the M+C organization decides to expedite the request, it must render a decision as expeditiously as the enrollee's health condition might require, but no later than 72 hours after receiving the enrollee's request.

4. If the M+C organization denies the request for an expedited organization determination, the organization follows the requirements specified in §50.3.

50.2 - How the M+C Organization Processes Requests for Expedited Organization Determinations

(Rev. 22, 05-09-03)

The M+C organization must establish and maintain procedures that:

1. Establish efficient and convenient means for enrollees to submit oral/written requests;

2. Document all oral requests in writing and maintain the documentation in the case file;

3. Promptly decide whether to expedite a determination based on whether applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function; and

4. Develop a meaningful process for receiving requests for expedited reviews. These procedures should include designating an office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited organization determinations. The procedures must be clearly explained in member materials. In addition, M+C organizations will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical groups or other health plan offices are referred immediately to the M+C organization's designated office or department. The 72-hour period begins when the request is received by the appropriate office or department designated by the M+C organization regardless of whether the provider is under contract to the M+C organization. If the M+C organization requires medical information from noncontract providers to make a decision, the M+C organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited organization determination. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the M+C organization in

meeting the required timeframe. Regardless of whether the M+C organization must request information from noncontract providers, the M+C organization is responsible for meeting the same timeframe and notice requirements as it does with contracting providers.

50.2.1 - Defining the Medical Exigency Standard

(Rev. 22, 05-09-03)

The medical exigency standard requires an M+C organization and CMS' independent review entity to make decisions as "expeditiously as the enrollee's health condition requires." This standard is set forth in regulation at 422.568(a) (standard organization determination), 422.572(a) (expedited organization determination), 422.590(a) (standard reconsideration), 422.590(d)(1) (expedited reconsideration) and 422.592(b) (for reconsidered determination by independent review entity), 422.618(a) (M+C organization effectuating standard reconsidered determination), 422.618(b)(1) (effectuation requirements for reversals by the independent review entity), 422.618(c) (effectuation requirements for reversals by the ALJ or higher levels of appeal), 422.619 (effectuation requirements for expedited reconsidered determinations), 422.619(a) (M+C organization effectuating expedited reconsidered determinations), 422.619(b) (effectuation requirements for reversals by the independent review entity for expedited reconsidered determinations), 422.619(c) (effectuation requirements for reversals by the ALJ or higher levels of appeal for expedited reconsidered determinations). This standard requires that the M+C organization or the independent entity apply, at a minimum, established, accepted standards of medical practice in assessing an individual's medical condition. Evidence of the individual's condition can be demonstrated by indications from the treating provider or from the individual's medical record (including such information as the individual's diagnosis, symptoms, or test results).

The medical exigency standard was established by regulation to ensure that M+C organizations would develop a system for determining the urgency of both standard and expedited requests for services, triage incoming requests against pre-established criteria, and then give each request priority according to that system. That is, M+C organizations must treat every case in a manner that is appropriate to its medical particulars or urgency. M+C organizations should not systematically take the maximum time permitted for service-related decisions.

50.3 - Action Following Denial for Expedited Review

(Rev. 22, 05-09-03)

If an M+C organization denies a request for an expedited organization determination, it must automatically transfer the request to the standard timeframe and make a determination within 14 calendar days (the 14-day period starts when the request for an expedited determination is received by the M+C organization), give the enrollee prompt

oral notice of the denial including the enrollee's rights, and subsequently deliver to the enrollee, within 3 calendar days, a written letter of the enrollee's rights that:

1. Explains that the organization will automatically transfer and process the request using the 14-day timeframe for standard determinations;

2. Informs the enrollee of the right to file a grievance if he or she disagrees with the organization's decision not to expedite the determination;

3. Informs the enrollee of the right to resubmit a request for an expedited determination and that if the enrollee gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the request will be expedited automatically; and

4. Provides instructions about the grievance process and its timeframes.

50.4 - Action on Accepted Requests for Expedited Determinations

(Rev. 22, 05-09-03)

If an organization grants a request for an expedited determination, the determination must be made in accordance with the following requirements:

1. An M+C organization that approves a request for expedited determination must make the determination and notify the enrollee and the physician involved, as appropriate, of its decision. Whether the decision is adverse or favorable, the M+C organization must make its decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

2. The M+C organization will extend the 72-hour timeframe by up to 14 calendar days if the enrollee requests the extension. The M+C organization also may extend the timeframe by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When the M+C organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.

If the M+C organization first notifies the enrollee of its expedited determination orally, it then must mail written confirmation to the enrollee within 3 calendar days of the oral notification.

50.5 - Notification of the Result of an Expedited Organization Determination

(Rev. 22, 05-09-03)

The M+C organization must use approved notice language in Appendix 1. The standardized denial notice form has been written in a manner that is understandable to the enrollee and provides:

1. The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;

2. Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf;

3. A description of both the standard and expedited reconsideration processes should include conditions for obtaining an expedited reconsideration, and the other elements of the appeals process; and

4. The beneficiary's right to submit additional evidence in writing or in person.

60 - Appeals

(Rev. 22, 05-09-03)

60.1 - Parties to the Organization Determination for Purposes of an Appeal

(Rev. 22, 05-09-03)

The parties to an organization determination include:

1. The enrollee (including his or her authorized representative);

2. An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);

3. The legal representative of a deceased enrollee's estate; or

4. Any other provider or entity (other than the M+C organization) determined to have an appealable interest in the proceeding.

Any of these parties can request an appeal, with the exception that only the enrollee (or an enrollee's authorized representative) or a physician can request an expedited organization determination (that does not involve a request for payment of services).

60.1.1 - Representative Filing on Behalf of the Enrollee

(Rev. 27, 07-25-03)

An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative. A representative who is appointed by the court or who is acting in accordance with state law may also file an appeal for an enrollee. With the exception of incapacitated or legally incompetent enrollees where appropriate legal papers, or other legal authority, support this representation, both the enrollee making the appointment and the representative accepting the appointment must sign, date, and complete an appointment of representative form or similar written statement. If the appointed representative is an attorney, only the enrollee needs to sign the appointment of representative form or similar statement.

The representative statement must include the enrollee's name and Medicare number. The enrollee may use Form CMS-1696-U4 or SSA-1696-U4 (Appendix 4 and Appendix 5 respectively), Appointment of Representative (available at Social Security offices), although it is not required. The enrollee may also use the appointment of representative statement provided in the IRE Reconsideration Processing Manual.

A signed form or statement must be included with the enrollee's appeal. A separate appointment of representative form or statement is required for each appeal.

Except in the case of incapacitated or incompetent enrollees, a request for reconsideration from a representative is not valid until supported with an executed appointment of representative form. It is the M+C organization's obligation to inform the enrollee and purported representative, in writing, that the reconsideration request will not be considered until the appropriate documentation is provided.

If a case file is initiated by a representative and submitted to the independent review entity, the independent review entity will examine the file for compliance with the appointment requirements. The independent review entity may dismiss cases in which a required appointment of representative form is absent.

When a request for reconsideration is filed by a person claiming to be a representative, but the party does not provide appropriate documentation upon the M+C organization's request, the M+C organization must make, and document, its reasonable efforts to secure the necessary appointment forms. The M+C organization should not undertake a review until or unless such forms are obtained. The timeframe for acting on a reconsideration request does not commence until the properly executed appointment form is received. However, if the M+C organization does not receive the form or statement at the conclusion of the appeal timeframe, plus extension, the M+C organization should forward the case to the independent review entity with a request for dismissal. The M+C organization must comply with the IRE Reconsideration Process Manual section on reconsiderations that fail to meet representative requirements.

A provider, physician, or supplier may not charge an enrollee for representation in an appeal.

Costs associated with the appeal are not reasonable costs for Medicare reimbursement purposes.

A representative who is a surrogate acting in accordance with state law may file an appeal. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute.

60.1.2 - Authority of a Representative

(Rev. 22, 05-09-03)

On behalf of an enrollee, a representative may:

1. Obtain information about the enrollee's claim to the extent consistent with current Federal and state law;

2. Submit evidence;

3. Make statements about facts and law; and

4. Make any request or give any notice about the proceedings.

60.1.3 – Noncontracted Provider Appeals

(Rev. 27, 07-25-03)

A noncontracted provider is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal. See Appendix 6.

Physicians and suppliers who have executed a waiver of beneficiary liability are not required to complete the representative form. In this case, the physician or supplier is not representing the beneficiary, and thus does not need a written appointment of representation.

When a noncontracted provider files a request for reconsideration of a denied claim but the provider does not submit the waiver of liability documentation upon the M+C organization's request, the M+C organization must make, and document, its reasonable efforts to secure the necessary waiver of liability form. The M+C organization should not undertake a review until or unless such form is obtained. The timeframe for acting on a reconsideration request does not commence until the properly executed waiver of liability form is received. However, if the M+C organization does not receive the form at the conclusion of the appeal timeframe, the M+C organization should forward the case to the independent review entity with a request for dismissal. The M+C organization

must comply with the IRE's Reconsideration Process Manual section on reconsiderations that fail to meet provider-as-party requirements.

60.2 - Written Explanation of the Appeals Process

(Rev. 22, 05-09-03)

The M+C organization must inform all enrollees, in writing, of the appeal procedures including a written description in each of the following situations:

1. At initial enrollment as part of the enrollee's membership materials;

2. Each year in the Evidence of Coverage;

3. At the time of any denial of payment or service, in whole or in part; and

4. Upon request, by the enrollee or his/her legal representative.

The M+C organization must clearly distinguish between grievance issues and appeal issues in all of the written explanations. The steps of the Medicare appeals procedure, the time limits, amount in controversy requirements, and procedures for filing appeals must be described in member materials.

60.3 - Steps in the Appeals Process

(Rev. 22, 05-09-03)

There are five levels of appeal available to Medicare beneficiaries enrolled in plans offered by M+C Organizations after an adverse organization determination has been made. These levels are to be followed sequentially only if the original denial continues to be upheld at each level by the reviewing entity:

1. Reconsideration of an adverse organization determination by the M+C organization;

2. Reconsideration of an adverse organization determination by the independent review entity;

3. Hearing by an Administrative Law Judge, if at least $100 is at issue;

4. Departmental Appeals Board (DAB) Review; and

5. Judicial Review, if at least $1000 is at issue.

70 - Reconsideration

(Rev. 22, 05-09-03)

The M+C organization's denial notice must inform the enrollee of his/her right to a reconsideration and the right to be represented by an attorney or other representative in the reconsideration process. Instructions on how and where to file a request for reconsideration must also be included. In addition, the member handbook or other materials must include information about free legal services available for qualified individuals. The reconsideration consists of a review of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence that the parties submit or that is obtained by the M+C organization or the independent review entity.

70.1 - Who May Request Reconsideration

(Rev. 22, 05-09-03)

Any party to an organization determination (including a reopened and revised determination), i.e. an enrollee, an enrollee's authorized representative or a noncontracted physician or provider to the M+C organization, may request that the determination be reconsidered. However, contracted providers do not have appeal rights. An enrollee, an enrollee's authorized representative, or physician (regardless of whether the physician is affiliated with the M+C organization) on the other hand, are the only parties who may request that an M+C organization expedite a reconsideration.

When a noncontracted physician or provider seeks a standard reconsidered determination for purposes of obtaining payment only, then the noncontracted physician or provider must sign a waiver of liability, i.e., the noncontracted physician or provider formally agrees to waive any right to payment from the enrollee for a service.

70.2 - How to Request a Standard Reconsideration

(Rev. 22, 05-09-03)

A party may request a standard reconsideration by filing a signed written request with the M+C organization, SSA office, or, in the case of a qualified Railroad Retirement Board (RRB) beneficiary, an RRB office. Except in the case of an extension of the filing timeframe, a party must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination. Requests made at an office of the SSA or RRB will be forwarded to the M+C organization for reconsideration; however, the timeframe for review does not begin until the M+C organization receives the request for reconsideration.

If an M+C organization chooses to accept an oral appeal request, the M+C organization should process the request as follows:

1. The request should be recorded in the enrollee's own words, repeated back to the member to confirm the accuracy, and placed into a tracking system;

2. If a department other than one that responds to appeals receives the request, it should forward the request to the appropriate department handling appeals;

3. The department handling appeals should mail an acknowledgement letter to the enrollee to confirm the facts and basis of the appeal, and request that the enrollee sign and return the acknowledgement letter; and

4. The M+C organization should not issue a final decision on the appeal until it receives the signed acknowledgement letter, or other signed document relevant to the appeal request.

70.3 - Good Cause Extension

(Rev. 22, 05-09-03)

If a party shows good cause, the M+C organization may extend the timeframe for filing a request for reconsideration. The M+C organization should consider the circumstance that kept the enrollee from making the request on time and whether any organizational actions might have misled the enrollee. Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

1. The enrollee did not personally receive the adverse organization determination notice, or he/she received it late;

2. The enrollee was seriously ill, which prevented a timely appeal;

3. There was a death or serious illness in the enrollee's immediate family;

4. An accident caused important records to be destroyed;

5. Documentation was difficult to locate within the time limits;

6. The enrollee had incorrect or incomplete information concerning the reconsideration process; or

7. The enrollee lacked capacity to understand the timeframe for filing a request for reconsideration.

The party requesting the good-cause extension may file the request with the M+C organization, the SSA office, or RRB office in writing, including the reason why the request was not filed timely. If the M+C organization denies an enrollee's request for a good cause extension, the enrollee may file a grievance with the M+C organization.

70.4 - Withdrawal of Request for Reconsideration

(Rev. 22, 05-09-03)

The party who files a request for reconsideration may withdraw the request at any time before a decision is mailed by writing to the M+C organization, SSA office, or RRB office.

70.5 - Opportunity to Submit Evidence

(Rev. 22, 05-09-03)

The M+C organization must provide the parties to the reconsideration reasonable opportunity to present evidence and allegations of fact or law related to the issues in dispute. Parties must be allowed to present such evidence in person or in writing. However, the enrollee is not required to submit additional evidence, but may exercise this right if the enrollee chooses.

The M+C organizations must take the evidence into account when making a decision. In addition, the M+C organization must, upon an enrollee's request, provide the enrollee with a copy of the contents of the case file, including but not limited to, a copy of supporting medical records and other pertinent information used to support the decision. The M+C organization must abide by all Federal and state laws regarding confidentiality and disclosure for mental health records, medical records, or other health information. See
45 CFR 164.500 et. seq. (regarding the privacy of individually identifiable health information).

The M+C organization must make every reasonable effort to accommodate an enrollee's request for case file material including, but not limited to, allowing the enrollee or authorized representative to obtain the material at a plan location (such as the office of a plan physician or other provider with whom the M+C organization has a business relationship) or mailing the material to any address specified by the enrollee or authorized representative. The M+C organization shall have the right to charge the enrollee a reasonable amount (e.g., comparable to charges established by a QIO) for duplicating the case file material. At the time the request for case file material is made, the M+C organization should inform the enrollee of the per page duplicating cost, and based on the extent of the case file material requested, provide a learned estimate of the total duplicating cost for which the enrollee will be responsible. The M+C organization may also charge the enrollee the cost of mailing the material to the address specified. The M+C organization may not charge the enrollee an additional cost for courier delivery of the material to a plan location that would be over and above the cost of mailing the material to the enrollee.

In the case of an expedited reconsideration, the opportunity to present evidence is limited by the short timeframe for making a decision. Therefore the M+C organization must inform the parties of the conditions for submitting the evidence, including reminding the enrollee that a 14 calendar day extension can be given if the enrollee feels he/she will need additional time.

70.6 - Who Must Reconsider an Adverse Organization Determination

(Rev. 22, 05-09-03)

The M+C organization must designate someone other than the person involved in making the initial organization determination when reviewing a reconsideration. If the original denial was based on a lack of medical necessity, then the reconsideration must be performed by a physician with expertise in the field of medicine that is appropriate for the services at issue.

In cases involving emergency services, the M+C organization must apply the prudent layperson standard when making the reconsideration determination.

70.6.1 - Meaning of Physician with Expertise in the Field of Medicine

(Rev. 22, 05-09-03)

The physician need not, in all cases, be of the same specialty or subspecialty as the treating physician. The physician must, however, possess the appropriate level of training and expertise to evaluate the necessity of the service. This does not require that the physician always possess identical specialty training.

For example, there may be situations where only one specialist practices in a rural area, and therefore, it would not be possible for the M+C organization to obtain a second reviewer with expertise in the same specialty. In addition, there may be some situations where there are few practitioners in highly specialized fields of medicine. Under these types of circumstances, it would not be possible to get physicians of the same specialty or sub-specialty involved in the review of the adverse organization determination.

70.7. - Timeframes and Responsibilities for Conducting Reconsiderations

(Rev. 22, 05-09-03)

70.7.1 - Standard Reconsideration of the Denial of a Request for Service

(Rev. 22, 05-09-03)

Upon reconsideration of an adverse organization determination, the M+C Organization must make its reconsidered determination as expeditiously as the enrollee's health condition requires. This must be no later than 30 calendar days from the date the M+C

organization receives the request for a standard reconsideration. The timeframe will be extended by up to 14 calendar days by the M+C organization if the enrollee requests the extension or also may be extended by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When the M+C organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant itself an extension. When extensions are used, the organization must issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon the expiration date of the extension.

Occasionally, the M+C organization may not have complete documentation for a reconsideration request. The organization must make reasonable and diligent efforts to obtain all necessary medical records and other pertinent information within the required time limits. If the M+C organization cannot obtain all relevant documentation, it must make the decision based on the material available.

70.7.2 - Affirmation of a Standard Adverse Organization Determination

(Rev. 22, 05-09-03)

If the M+C organization makes a reconsidered determination that affirms in whole or in part, its adverse organization determination, it must prepare a written explanation and send the complete case file to the independent review entity contracted by CMS. This must be completed as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date the M+C organization receives the request for a standard reconsideration, or no later than the end of any extension. The M+C organization must make reasonable and diligent efforts to gather and forward all pertinent information to the independent review entity. The M+C organization must also notify the enrollee that the case has been forwarded to the independent review entity.

If CMS determines that the M+C organization has a pattern of not making a reasonable and diligent effort to gather and forward information to the independent review entity, the M+C organization will be considered to be in breach of its Medicare contract.

70.7.3 - Standard Reconsideration of the Denial of a Request for Payment

(Rev. 22, 05-09-03)

If upon reconsideration the M+C organization overturns its adverse organization determination denying an enrollee's request for payment, then the M+C organization must issue its reconsidered determination and send payment for the service to the enrollee. This must be mailed no later than 60 calendar days from the date it received the request for a standard reconsideration.

If the M+C organization affirms, in whole or in part, its adverse organization determination (i.e., continues to deny payment in whole or in part), it must prepare a written explanation and send the complete case file to the independent review entity contracted by CMS. This must be completed no later than 60 calendar days from the date it receives the request for a standard reconsideration. The M+C organization must make reasonable and diligent efforts to gather and forward information to the independent review entity. The M+C organization must also notify the enrollee that the case has been forwarded to the independent review entity. If CMS determines that the M+C organization has a pattern of not making a reasonable and diligent effort to gather and forward information to the independent review entity, the M+C organization will be considered to be in breach of its Medicare contract.

70.7.4 - Effect of Failure to Meet the Timeframe for Standard Reconsideration

(Rev. 22, 05-09-03)

If the M+C organization fails to provide the enrollee with a reconsidered determination within the timeframes specified in §80.4 this failure constitutes an affirmation of the adverse organization determination. In this case, the M+C organization must submit the complete file to the independent review entity, according to the procedures set forth in §80.5. If CMS determines that the M+C organization has a pattern of not concluding its standard reconsiderations within the required timeframes or not making reasonable and diligent effort to gather and forward information to the independent review entity, then the M+C organization will be considered to be in breach of its Medicare contract.

80 - Expediting Certain Reconsiderations

(Rev. 22, 05-09-03)

An enrollee or any physician (regardless of whether the physician is affiliated with the M+C organization) may request that an M+C organization expedite a reconsideration of a determination, in situations where applying the standard procedure could seriously jeopardize the enrollees life, health, or ability to regain maximum function, including cases in which the M+C organization makes a less than fully favorable decision to the enrollee. In light of the short timeframe for deciding expedited reconsiderations, a physician does not need to be an authorized representative to request an expedited reconsideration on behalf of the enrollee. A request for payment of a service already provided to an enrollee is not eligible to be reviewed as an expedited reconsideration.

To ask for an expedited reconsideration, an enrollee or a physician must submit an oral or written request directly to the organization or entity responsible for making the reconsideration. A physician may provide oral or written support for a request made by an enrollee for an expedited reconsideration. The M+C organization must provide an expedited determination if a physician indicates that applying the standard timeframe

could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

80.1 - How the M+C Organization Processes Requests for Expedited Reconsideration

(Rev. 22, 05-09-03)

The organization must establish and maintain procedures for expediting reconsiderations. These include establishing an efficient and convenient method for individuals to submit oral or written requests for expedited appeals, documenting oral requests, and maintaining the documentation in the case file. The M+C organization must designate an office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals. The M+C organization must promptly decide whether to expedite or follow the timeframe for standard reconsiderations.

If an M+C organization denies a request for an expedited reconsideration, it must automatically transfer the request to the standard reconsideration process and then make its determination as expeditiously as the enrollee's health condition requires. This should be done no later than within 30 calendar days from the date the M+C organization received the request for expedited reconsideration. The M+C organization must also provide the enrollee with prompt oral notice of the denial of the request for reconsideration and the enrollee's rights, and subsequently deliver to the enrollee within 3 calendar days of the oral notification, a written letter that:

1. Explains that the M+C organization will automatically transfer and process the request using the 30-day timeframe for standard reconsiderations;

2. Informs the enrollee of the right to file a grievance if he or she disagrees with the organization's decision not to expedite the reconsideration;

3. Informs the enrollee of the right to resubmit a request for an expedited reconsideration and that if the enrollee gets any physician's support indicating that applying the standard timeframe for making a determination could seriously jeopardize the enrollee's life, health or ability to regain maximum function, the request will be expedited automatically; and

4. Provides instructions about the grievance process and its timeframes.

Delivery does not mean that the notice actually be in the hands of the enrollee within 3 calendar days, but instead mailed to the enrollee within 3 calendar days.

If the M+C organization approves a request for an expedited reconsideration, then it must complete the expedited reconsideration and give the enrollee (and the physician involved, as appropriate) notice of its decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request. If the request is made or

supported by a physician, the M+C organization must grant the expedited reconsideration request when the physician indicates that the life or health of the enrollee, or the enrollee's ability to regain maximum function could be jeopardized by applying the standard timeframe in the processing of the reconsideration request.

The 72-hour timeframe must be extended by up to 14 calendar days if the enrollee requests the extension. The timeframe also may be extended by up to 14 calendar days if the M+C organization justifies a need for additional information and documents how the extension is in the interest of the enrollee, e.g., the receipt of additional medical evidence from a noncontract provider may change an M+C organizations decision to deny. When the M+C organization extends the timeframe, it must notify the enrollee in writing of the reasons for the extension, and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the last day of the extension.

If the M+C organization requires medical information from noncontract providers, the M+C organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited reconsideration. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the M+C organization in meeting the required timeframe. Regardless of whether the M+C organization must request information from noncontract providers, the M+C organization is responsible for meeting the same timeframe and notice requirements as it does with contracting providers.

If an enrollee misses the noon deadline to file for immediate QIO review of an inpatient hospital discharge, then the enrollee may request an expedited appeal with the M+C organization. While an M+C organization uses discretion as to whether to expedite a request, the M+C organization is encouraged to automatically expedite all requests to appeal inpatient hospital discharges. Additionally, the M+C organization is encouraged to automatically expedite all requests to appeal skilled nursing facility (SNF) and physical therapy discontinuations.

80.2 - Effect of Failure to Meet the Timeframe for Expedited Reconsideration

(Rev. 22, 05-09-03)

If an M+C organization does not notify the enrollee within the required timeframes set forth in this chapter for expedited reconsideration, this constitutes an adverse decision. In this case the M+C organization must submit the complete file to the independent review entity according to the procedures set forth in this chapter. If CMS determines that the M+C organization has a pattern of not concluding its expedited reconsiderations within the required timeframes or not making reasonable and diligent efforts to gather and forward information to the independent review entity, then the M+C organization will be considered to be in breach of its Medicare contract.

80.3 - Forwarding Adverse Reconsiderations to the Independent Review Entity

(Rev. 22, 05-09-03)

If an M+C organization affirms the adverse organization determination (in whole or in part) it must submit a written explanation with the complete case file to the independent review entity contracted by CMS within the timeframes appropriate for standard and expedited cases, as set forth in this chapter. The M+C organization must submit a hard copy case file to the independent review entity by mail or overnight delivery service at its designated address. The M+C organization should refer to the independent review entity's Reconsideration Process Manual for additional instructions.

The M+C organization must notify the enrollee that it has forwarded the case to the independent entity for review. The notice also must advise the enrollee of his/her right to submit additional evidence that may be pertinent to the enrollee's case, if the enrollee chooses. The notice must direct the enrollee to submit such evidence to the independent review entity, and must include information on how to contact the independent review entity.

80.4 - Timeframes for Forwarding Adverse Reconsiderations to the Independent Review Entity

(Rev. 22, 05-09-03)

The M+C organization must forward the enrollee's case file within the following regulatory timeframes:

1. For standard requests for service, the M+C organization must forward an enrollee's case file to the independent review entity as expeditiously as the enrollee's health condition requires. This must be completed no later than 30 calendar days from the date the M+C organization receives the enrollee's request for reconsideration (or no later than upon the expiration of an extension).

2. For expedited reconsiderations, the M+C organization must forward the enrollee's case file to the independent review entity as expeditiously as the enrollee's health condition requires, but no later than within 24 hours of affirmation of its adverse expedited organization determination.

3. For requests for payment, the M+C organization must forward the enrollee's case file to the independent review entity no later than 60 calendar days from the date it receives the request for a standard reconsideration.

80.5 - Preparing the Case File for the Independent Review Entity

(Rev. 22, 05-09-03)

Give each file a separate folder, labeled with the member's name and Health Insurance Claim (HIC) number.

The actual case file will contain:

1. An Appeal Transmittal Cover Sheet on top of the case file, so that the independent review entity can clearly differentiate new cases from other incoming materials;

2. Reconsideration Background Data Form, which is a standard data collection document with supplementary narrative description and attachments; and

3. Case Narrative.

M+C organizations should refer to the most current version of the Independent Review Entity's Reconsideration Process Manual for information concerning the Appeal Transmittal Cover Sheet and the Reconsideration Background Data Form.

90 - Reconsiderations by the Independent Review Entity

(Rev. 22, 05-09-03)

The independent review entity must conduct the reconsideration as expeditiously as the enrollee's health condition requires and should observe the same timeframes as required for M+C organizations. When the independent review entity conducts its reconsideration, the parties to the reconsideration are the parties listed in §60.1 of this chapter as well as the M+C organization.

When the independent review entity completes its reconsidered determination, it is responsible for notifying all the parties of the reconsidered determination, and for sending a copy of the reconsidered determination to the appropriate CMS Regional Office.

The determination notice of the independent review entity must be stated in understandable language and in a culturally competent manner taking into account the enrollees presenting medical condition, disabilities, and special language requirements, if any, and:

1. Include specific reasons for the entity's decisions;

2. Inform parties, other than M+C organization of their right to an ALJ hearing if the amount in controversy is $100 or more, and if the decision is adverse (i.e., does not completely reverse the organization's adverse determination); and

3. Describe procedures that the parties must follow to obtain an ALJ hearing.

90.1 – Storage of Appeal Case Files by the Independent Review Entity

(Rev. 27, 07-25-03)

The CMS' independent review entity stores the appeal case files for a period of seven years from the end of the calendar year in which final action is taken. The inventory of case files include the reconsideration case files forwarded from the M+C organization and processed by the independent review entity which are not appealed further, as well as ALJ hearing case files returned to the independent review entity.

100 - Administrative Law Judge (ALJ) Hearings

(Rev. 22, 05-09-03)

If the amount remaining in controversy is $100 or more, any party to the reconsideration (with the exception of the M+C organization) who is dissatisfied with the reconsidered determination has a right to a hearing before an ALJ.

The amount remaining in controversy, which can include any combination of Part A and B services, is computed in accordance with 42 CFR 405.740 for Part A services and 42 CFR 405.817 for Part B services. Other services for which an enrollee is entitled under a plan's benefit package may be used to reach the threshold amount. See 42 CFR 422.100 for a description of the types of services covered by M+C organizations.

If the basis for the appeal is the M+C organization's refusal to provide services, the projected value of those services is used to compute the amount remaining in controversy. If the basis for the appeal is the M+C organization's refusal to cover optional or supplemental benefits, the projected value of those benefits is used to compute the amount remaining in controversy.

100.1 - Request for an ALJ Hearing

(Rev. 22, 05-09-03)

A request for an ALJ hearing must be in writing and can be filed with the M+C organization, an SSA office, an RRB office, or with CMS' independent review entity. If the M+C organization receives a written request for an ALJ hearing from the enrollee, the M+C organization must immediately forward the enrollee's request to the IRE. The independent review entity is responsible for compiling the reconsideration file and forwarding it to the appropriate ALJ hearing office.

Except when an ALJ extends the timeframe as provided in 20 CFR 404.933(c), a party must file a request for an ALJ hearing, within 60 days of the date of the notice of a reconsidered determination. Any request for a "good cause" extension must be in writing and state the reasons why the request was late. If the party shows good cause for missing

the deadline, the ALJ may grant an extension. (See 20 CFR 404.911 for the ALJ standards for "good cause.")

The parties to an ALJ hearing are the same as those for the reconsideration, and also include the M+C organization and any other person or entity whose rights with respect to the reconsideration may be affected by the hearing, as determined by the ALJ. Although the M+C organization does not have a right to request an ALJ hearing, it must be made a party to the hearing. Fees for services provided by the M+C organization representative are not subject to regulations at 20 CFR 404.1720, which govern appointment of representatives and payment of fees to representatives at the ALJ hearing level of appeal.

100.2 - Determination of Amount in Controversy

(Rev. 22, 05-09-03)

The ALJ determines whether the amount remaining in controversy (for both Part A and Part B services) is $100 or more. For cases involving denied services, the projected value of the services is used to determine whether the amount in controversy is $100 or more. For cases involving optional or supplemental benefits, but not employer-sponsored benefits limited to employer group members, the projected value of those benefits is used to determine whether the amount in controversy is $100 or more. The M+C organization is expected to cooperate with the ALJ and assist in the computation of the amount in controversy. The hearing may be conducted on more than one claim at a time; i.e., the enrollee may have several claims involving several issues. The enrollee may combine claims to meet the $100 limitation, if the following requirements are met:

1. The claims must belong to the same beneficiary;

2. The claims must each have received a determination through the independent review entity reconsideration process;

3. The 60-day filing time limit must be met for all claims involved; and

4. The hearing request must identify all claims.

The ALJ dismisses cases involving less than $100. If, after a hearing is initiated, the ALJ finds that the amount in controversy is less than $100, he/she discontinues the hearing and does not rule on the substantive issues raised in the appeal. Any party may request review of the dismissal of a hearing through the Departmental Appeals Board (DAB) review.

110 - Departmental Appeals Board (DAB) Review

(Rev. 22, 05-09-03)

Any party dissatisfied with the ALJ hearing decision (including the M+C organization) may request that the DAB review the ALJ's decision or dismissal. Regulations located at

20 CFR 404.967 through 404.984 regarding Appeals Council Review apply to DAB review for matters addressed in this chapter.

The DAB may grant or deny the request for review. If it grants the request, it may either issue a final decision or dismissal, or remand the case to the ALJ with instructions on how to proceed with the case.

110.1 - Filing a Request for DAB Review

(Rev. 22, 05-09-03)

A request for a DAB review must be filed by writing a letter to the DAB. A request may be submitted to an office of the Railroad Retirement Board (for railroad retirees) or directly to the DAB at the following address:

Department of Health and Human Services
Departmental Appeals Board, HHH Building
200 Independence Avenue SW, Room 637D
Washington, DC 20201

If an M+C organization decides to request a DAB review, the organization must concurrently notify the enrollee of this action by sending a copy of the request, as well as accompanying documents, that the organization submits to the DAB.

110.2 - Time Limit for Filing a Request for DAB Review

(Rev. 22, 05-09-03)

The request for a DAB review must be filed within 60 days of the date of receipt of the ALJ hearing decision or dismissal. The DAB assumes the ALJ decision was received within 5 days of the date of the decision, unless evidence indicates otherwise. The DAB may grant an extension of the request for a review if the party can show "good cause" for missing the deadline. (See 20 CFR 404.911 for the standards applicable for determining "good cause.")

110.3 - DAB Initiation of Review

(Rev. 22, 05-09-03)

The DAB may initiate a review on its own motion within 60 days after the date of an ALJ hearing decision or dismissal. If the DAB initiates a review, it mails notice of this action to all parties at their last address of record.

110.4 - DAB Review Procedures

(Rev. 22, 05-09-03)

The DAB will review a case if:

1. There appears to be an abuse of discretion by the ALJ;

2. There is an error of law;

3. The action, findings or conclusions of the ALJ are not supported by substantial evidence; or

4. There is a broad policy or procedural issue that may affect the general public interest.

If new and material evidence is submitted, the DAB shall consider the additional evidence only where it relates to the period on or before the date of the ALJ hearing decision. The DAB shall evaluate the entire record, including the new and material evidence submitted if it relates to the period on or before the date of the ALJ hearing decision. It will then review the case if it finds that the ALJ's action, findings, or conclusions is contrary to the weight of the evidence currently of record.

A copy of the DAB's decision will be mailed to the parties at their last known address.

120 - Judicial Review

(Rev. 22, 05-09-03)

Any party, including the M+C organization (upon notifying all the other parties), may request judicial review of an ALJ's decision if:

1. The DAB denied the parties request for review; and

2. The amount in controversy is $1,000 or more.

In addition, any party, including the M+C organization (upon notifying all the other parties), may request judicial review of a DAB decision if:

1. The DAB denied the parties request for review; or

2. It is the final decision of CMS; and

3. The amount in controversy is $1,000 or more.

The enrollee may combine claims to meet the $1,000 amount in controversy requirement. To meet the requirement:

1. All claims must belong to the same enrollee;

2. The DAB must have acted on all the claims;

3. The enrollee must meet the 60-day filing time limit for all claims; and

4. The requests must identify all claims.

A party may not obtain judicial review unless the DAB has acted on the case - either in response to a request for review or on its own motion.

120.1 - Requesting Judicial Review

(Rev. 22, 05-09-03)

A party must file a civil action in a district court of the United States in accordance with §205(g) of the Act (see 20 CFR 422.210 for a description of the procedures to follow in requesting judicial review). The action should be initiated in the judicial district in which the enrollee lives or where the M+C organization has its principal place of business. If neither the organization nor the member is in such judicial district, the action should be filed in the United States district court for the District of Columbia.

130 - Reopening and Revising Determinations and Decisions

(Rev. 22, 05-09-03)

An organization or reconsideration determination made by an M+C organization, a reconsidered determination made by the independent review entity, or the decision of the ALJ or DAB that is otherwise final and binding, may be reopened and revised only by the entity that made the determination or decision. A reopening may be initiated by any of the aforementioned parties to the determination or decision as described in this chapter.

Reopening occurs after a decision has been made, generally to correct an error, in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the complaint was initially processed. A reopening is not an appeal right. It is an administrative procedure under which the entity that made a determination re-examines that decision for a specific reason. The decision to reopen a case is at the discretion of the entity that made the determination. The entity's decision on whether to grant a reopening is not appealable.

Typically, the reopening is only requested after the exhaustion of appeal rights. However, a party may request a reopening even if it still has appeal rights, as long as the guidelines for reopening are met. For example, if an enrollee receives an adverse reconsidered determination, but later obtains relevant medical records, he or she may request a reopening rather than a hearing before an ALJ. However, if the enrollee did not have additional information and just disagreed with the reasoning of the decision, he or she must file for the appeal.

If a party requests a reopening while it still has appeal rights, it also files for the appeal and asks for a continuance until a reopening is decided. If the reopening is denied or the original determination is not revised, the party retains its appeal rights.

The filing of a request for a reopening does not relieve the M+C organization of its obligation to make payment for, authorize, or provide services as specified in this chapter. Once a revised determination or decision is issued, any party may appeal the new determination or decision.

130.1 - Guidelines for a Reopening

(Rev. 22, 05-09-03)

The following are guidelines for a reopening request:

1. The request must be made in writing;

2. The request for a reopening must be clearly stated;

3. The request must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted); and

4. The request should be made within the timeframes permitted for reopening (as set forth in §130.2).

130.2 - Time Limits for a Reopening

(Rev. 22, 05-09-03)

A reopening may be filed:

1. Within 12 months of the date of the initial M+C organization determination or the reconsideration determination, for any reason;

2. After such 12-month period, but within 4 years of the date of the initial M+C organization determination or the reconsideration determination, for good cause as defined in §130.3; or

3. At any time when fraud or similar fault affected the M+C organization determination or the reconsideration determination.

130.3 - "Good Cause" for Reopening

(Rev. 22, 05-09-03)

"Good cause" exists where:

1. There is new and material evidence, not readily available at the time of the determination or decision, and consideration of this material may result in a different conclusion;

2. There is a clerical error in the file; or

3. There is an error on the face of the evidence, which affects the determination or decision.

130.4 - Definition of Terms in the Reopening Process

(Rev. 22, 05-09-03)

130.4.1 - Meaning of New and Material Evidence

(Rev. 22, 05-09-03)

The submittal of any additional evidence is not a basis for reopening in and of itself. "New and material evidence" is evidence not considered when making the previous decision. This evidence must show facts not previously available, which could possibly result in a different decision. New information also includes an interpretation of existing information (e.g., a different interpretation of a benefit).

130.4.2 - Meaning of Clerical Error

(Rev. 22, 05-09-03)

A clerical error includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding, and computer errors.

130.4.3 - Meaning of Error on the Face of the Evidence

(Rev. 22, 05-09-03)

An error on the face of the evidence exists if the determination or decision is clearly incorrect based on all the evidence present in the appeal file. For example, a piece of evidence could have been contained in the file, but misinterpreted or overlooked by the person making the determination.

140 - Effectuating Reconsidered Determinations or Decisions

(Rev. 22, 05-09-03)

140.1 - Effectuating Determinations Reversed by the M+C Organization

(Rev. 27, 07-25-03)

140.1.1 - Standard Service Requests

(Rev. 22, 05-09-03)

If the M+C organization completely reverses the initial adverse organization determination (i.e., initial service denial), the organization must authorize or provide the service under dispute as expeditiously as the enrollee health condition requires. However, service must be provided no later than 30 calendar days (or no later than upon expiration of an extension) from the date the request for reconsideration is received by the M+C organization.

140.1.2 - Expedited Service Requests

(Rev. 22, 05-09-03)

If on reconsideration of an expedited request for service the M+C organization completely reverses the initial organization determination, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but not later than 72 hours after the date the M+C organization receives the request for reconsideration (or no later than upon expiration of an extension).

140.1.3 - Payment Requests

(Rev. 22, 05-09-03)

If the M+C organization completely reverses the initial adverse organization determination (i.e., initial claim denial), the organization must pay for the service no later than 60 calendar days after the date it receives the request for reconsideration.

140.2 - Effectuating Determinations Reversed by the Independent Review Entity

(Rev. 22, 05-09-03)

140.2.1 - Standard Service Requests

(Rev. 22, 05-09-03)

If the M+C organization's decision is reversed in whole or in part by the independent review entity, the M+C organization must provide the services under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from the date it receives notice that the independent review entity reversed the determination. If it is not appropriate for the M+C organization to provide the service within 14 calendar days, e.g., because of the enrollee's medical condition or the enrollee is outside of the service area, then the M+C organization must authorize the services within 72 hours from the date it receives notice that the independent review entity reversed the determination. The M+C organization must inform the independent review entity that the M+C organization has effectuated the decision.

140.2.2 - Expedited Service Requests

(Rev. 22, 05-09-03)

If the M+C organization's determination is reversed in whole or in part by the independent review entity, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. The M+C organization must inform the independent review entity that the M+C organization has effectuated the decision.

140.2.3 - Payment Requests

(Rev. 22, 05-09-03)

The M+C organization must pay for the service no later than 30 calendar days from the date it receives notice of the reversal. The M+C organization must inform the independent review entity that the M+C organization has effectuated the decision.

The reconsidered determination of the independent review entity is final and binding on all parties unless an appropriate party requests an ALJ hearing or the case is revised. M+C organizations do not have the right to request an ALJ hearing.

140.3 - Effectuating Decisions by All Other Review Entities

(Rev. 22, 05-09-03)

If the organization determination is reversed in whole or in part by an ALJ, the DAB, or judicial review, the M+C organization must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the initial organization determination. The M+C organization must inform the independent review entity that the M+C organization has effectuated the decision.

140.4 - Independent Review Entity Monitoring of Effectuation Requirements

(Rev. 22, 05-09-03)

The CMS requires its independent review entity to monitor an M+C organization's compliance with determinations or decisions that fully or partially reverse an original M+C organization determination (denial). The process is as follows:

1. The independent review entity issues to the M+C organization a copy of the reconsidered determination. Included with this copy is a Notice of Requirement to Comply.

2. Pursuant to the compliance notice, the M+C organization is required to mail to the independent review entity a statement attesting to compliance with the independent review entity's decision. This documentation is to confirm when and how compliance occurred (e.g., service authorization, payment made, etc.). The M+C organization's notice of compliance should be forwarded to the independent review entity concurrent with the M+C organization's effectuation.

3. If the independent review entity does not obtain the compliance notice, it mails the M+C organization a reminder notice.

4. If the independent review entity does not receive the M+C organization's compliance report within 30 days of the reminder notice, the independent review entity reports the M+C organization's failure to comply to CMS. The M+C organization is not copied on the notice to CMS.

140.5 - Effectuation Requirements When an M+C Organization Non-Renews Its Contract

(Rev. 22, 05-09-03)

If an M+C organization terminates its contract with CMS, appeals that are pending with the independent review entity (IRE) after such termination must be effectuated if the IRE overturns the M+C organization's adverse organization determination. Since the M+C

contract and the regulations at 42 CFR 422.502(a)(3) require M+C organizations to provide access to benefits for the duration of their contract, M+C organizations are obligated to process and effectuate any appeals from organization determinations (in connection with both services and/or payment of services) which are determined to be covered, and which should have been provided or paid for while Medicare beneficiaries were enrolled in the plan. Thus, the terminating M+C organization is responsible for claims payments arising from decisions on pending appeals that are issued following termination of the contract.

150 - Notification to Enrollees of Noncoverage of Inpatient Hospital Care

(Rev. 22, 05-09-03)

Where an M+C organization has authorized coverage of the inpatient hospital admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care), the M+C organization is required to issue the enrollee a written notice of noncoverage only under the circumstances described in §150.2.

150.1 - Notice of Discharge and Medicare Appeal Rights (NODMAR)

(Rev. 22, 05-09-03)

The model NODMAR is a written notice that is designed to inform Medicare enrollees that their covered hospital care is ending. The NODMAR must include the following:

1. The specific reason why inpatient hospital care is no longer needed;

2. The prospective effective date of the enrollee's financial liability for continued inpatient care; and

3. The enrollee's appeal rights.

The model NODMAR (see Appendix 3) meets the notice requirements set forth in 42 CFR 422.620(c). We encourage M+C organizations to use this model form, but they are allowed to develop their own. (**NOTE**: The CMS is in the process of implementing a revised notice of noncoverage form through the Office of Management and Budget's Paperwork Reduction Act process.) All NODMARs must be approved by the M+C organization's Regional Office Plan Manager until such time that CMS issues a standardized form.

Before the M+C organization gives a NODMAR, the physician who is responsible for the enrollee's inpatient hospital care must concur with the decision to discharge the enrollee.

150.2 - When to Issue a NODMAR

(Rev. 22, 05-09-03)

Consistent with 42 CFR 422.620, M+C organizations (and hospitals that have been delegated responsibility by an M+C organization to make the discharge/noncoverage decision) will distribute the NODMAR only when:

1. The enrollee expresses dissatisfaction with his or her impending discharge; or

2. The M+C organization (or the hospital that has been delegated the responsibility) is not discharging the individual, but no longer intends to continue coverage of the inpatient stay.

The M+C organization (or hospital that has been delegated the responsibility) is not required to issue the NODMAR if the enrollee dies while in an inpatient hospital setting.

In determining whether continued inpatient hospital care is medically necessary, consider the level of care required by the enrollee and the availability and appropriateness of other facilities and services. For example, if the enrollee no longer requires acute care in an inpatient hospital, and could receive proper treatment at a skilled nursing facility (SNF), but a Medicare-certified SNF bed is not available, further care at the hospital may be medically necessary to permit the needed skilled services to continue. In such cases, a NODMAR should not be issued (see MIM §3421.1) until such time as a SNF bed becomes available and an actual discharge date can be determined.

An M+C organization should deliver the NODMAR as soon as possible after learning of an enrollee's dissatisfaction with the discharge decision, but no later than 6:00 p.m. of the day before discharge. If the enrollee is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the enrollee's authorized representative. (Note that this person would also likely be the individual who expressed dissatisfaction.)

160 - Requesting Immediate Quality Improvement Organization (QIO) Review of Inpatient Hospital Care

(Rev. 22, 05-09-03)

An enrollee remaining in the hospital that wishes to appeal the M+C organization's discharge decision that inpatient care is no longer necessary must request immediate QIO review of the determination in accordance with this section's requirements. An enrollee will not incur any additional financial liability if:

1. The enrollee remains in the hospital as an inpatient;

2. The enrollee submits the request for immediate review to the QIO that has an agreement with the hospital;

3. The request is made either in writing, by telephone or fax; and

4. The request is received by noon of the first working day after the enrollee receives written notice of the M+C organization's determination that the hospital stay is no longer necessary.

The following rules apply to the immediate QIO review process:

1. On the date that the QIO receives the enrollee's request, the QIO must notify the M+C organization that the enrollee has filed a request for immediate review;

2. The M+C organization and/or hospital must supply any information that the QIO requires to conduct its review. This must be made available by phone, fax, or in writing, by the close of business of the first full working day immediately following the day the enrollee submits the request for review;

3. In response to a request from the M+C organization, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day the M+C organization makes its request;

4. The QIO must solicit the views of the enrollee who requested the immediate QIO review; and

5. The QIO must make an official determination of whether continued hospitalization is medically necessary, and notify the enrollee, the hospital, and the M+C organization by close of business of the first working day after it receives all necessary information from the hospital, the M+C organization, or both.

An enrollee who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited reconsideration with the M+C organization. The M+C organization is encouraged to expedite the request for an expedited reconsideration. Likewise, if the QIO receives a request for immediate QIO review beyond the noon filing deadline and forwards that request to the M+C organization, the M+C organization should expedite that request. Thus, the M+C organization would generally make another decision about the services within 72 hours. However, the financial liability rules governing immediate QIO review do not apply in an expedited review situation.

160.1 - Liability for Hospital Costs

(Rev. 22, 05-09-03)

The presence of a timely appeal for an immediate QIO review as filed by the enrollee in accordance with this section entitles the enrollee to automatic financial protection by the M+C organization. This means that if the M+C organization authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, the M+C organization continues to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the QIO notifies the enrollee of its review determination.

170 - Data

(Rev. 22, 05-09-03)

M+C organizations are expected to disclose grievance and appeals data to eligible Medicare individuals upon request. M+C organizations should not send out a subset or partial list of the data, even if only a subset of the data is requested. For example, if a beneficiary requests data on the number of appeals received by the M+C organization, then the M+C organization would send the beneficiary a complete report of both its appeal and grievance data for the reporting period.

M+C organizations must report to beneficiaries the number of appeal and grievance requests per 1000 enrollees. The purpose of this calculation is to normalize reporting among larger and smaller M+C organizations for comparison purposes. Since larger organizations would reasonably be expected to receive more appeals and grievances relative to smaller organizations, simply reporting raw data could be misleading.

The rate is calculated by multiplying the total number of requests for [an appeal or grievance] by 1,000, and dividing that number by the average number of members enrolled during the data collection period. It does not require that the M+C organization have a minimal enrollment of 1000 members.

The following are examples of how the rates get normalized across small and large plans:

EXAMPLE 1

M+C organization average membership = 500

# of appeals received during the data collection period = 4

4 x 1000/500 = 8

# of Appeals per 1000 members = 8

EXAMPLE 2

M+C organization average membership = 5000

# of appeals received during the data collection period = 40

40 x 1000/5000 = 8

# of Appeals per 1000 members = 8

170.1 - Reporting Unit for Appeal and Grievance Data Collection Requirements

(Rev. 22, 05-09-03)

The reporting unit for appeal and grievance data sent to beneficiaries is to be consistent with the reporting unit for the Health Plan Employer Data and Information Set (HEDIS), the Medicare Consumer Assessment of Health Plans Study (CAHPS), and the Medicare Health Outcomes Survey (HOS). Generally, the reporting unit for appeal and grievance data is to be the same as for HEDIS, CAHPS and HOS; therefore, M+C organizations must make changes to the reporting unit for appeals and grievances concurrently. However, CMS retains the flexibility to grant special exceptions to the general reporting unit to allow for case-by-case exceptions for good cause.

170.2 - Data Collection and Reporting Periods

(Rev. 22, 05-09-03)

In order for M+C organizations to report appeal and grievance data consistently, data collection and reporting periods have been established.

1. The data collection period is the timeframe in which the data were collected. Data collection periods will be based on an ongoing 12-month period. By ongoing, we mean that the prior 6 months of data are added to the next 6 months of data in order to come up with a 12-month data collection period.

2. The reporting period refers to the timeframe during which organizations will be expected to report the data. The reporting period begins 3 months after the data collection period ends. Reporting periods are 6 months in duration.

3. Organizations are expected to report out appeal and grievance data to beneficiaries, upon request, beginning 3 months after the end of each data collection period. For example, if the data collection period ends 9/30/02, the organization will begin reporting data to the beneficiary 1/1/2003. The 3-month lag between the end of the data collection period and the beginning of the report period allows the M+C organization to resolve appeals received during the data collection period and ensure quality control over the data reported.

Below is a chart detailing the yearly collection and reporting cycles for 2002 - 2003.

Yearly Collection and Reporting Cycles for 2002 - 2003

6-month Data Collection	3-month Reconciliation	What kind of data?
4/1/02 - 9/30/02	10/1/02 - 12/31/02	last 6 months
10/1/02 - 3/31/03	4/1/03 - 6/30/03	last 12 months
4/1/03 - 9/30/03	10/1/03 - 12/31/03	last 12 months, etc.

170.3 - New Reporting Periods Start Every Six Months

(Rev. 22, 05-09-03)

M+C organizations are expected to report out new data every 6 months. The new data that get reported will include the two most recent data collection periods. For example, the data collection period would begin each year starting on April 1 and ending on September 30, thus the reporting period would run from January 1 through June 30. The next reporting period begins July 1 and runs through December 31. This report included appeal and grievance data collected beginning April 1 through March 31 (or the two latest 6 month data collection periods). As an example, beneficiary requests for appeal and grievance data beginning January 1, 2003, through June 30, 2003, would be based on appeals received by the organization from October 1, 2001, through September 30, 2002, and so on.

170.4 - Maintaining Data

(Rev. 22, 05-09-03)

The CMS expects M+C organizations to maintain a health information system that collects, analyzes and integrates the data necessary to implement disclosure requirements. M+C organizations will be monitored as part of the biennial review process to ensure that they have a reliable system to maintain and report accurate data.

170.5 - Appeal and Grievance Data Collection Requirements

(Rev. 22, 05-09-03)

The following describes the appeal data M+C organizations are expected to record and report. This format should be used by the M+C organization in recording the data internally and is the suggested format for reporting the information to beneficiaries. Reports should be readable and understandable to the recipient of the information. The material also should be typed in at least a 12-point font. The M+C organizations should

provide informational copies to the appropriate Regional Office. If the M+C organization provides any of its own materials or discussion to supplement CMS' model format, as with all member materials, prior approval by the Regional Office is required.

170.5.1 - Appeal Data

(Rev. 22, 05-09-03)

Line 1 Time Period Covered: **[Reporting Period lasts from 7/01/03 through 12/31/03, which includes data collected from 4/01/02 through 3/31/03.]**

Line 2. Total Number of Requests for an Appeal Received by **[Organization Name]*:* [insert # here].**

Instructions: This line includes all requests for reconsideration, including Pre-Service {standard & expedited} and Claims (Payment) Appeals.

Line 3. Average Number of Enrollees in **[Organization Name]**: **[insert # here]**.

Instructions: To calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by 12 (the total number of months in the data collection period).

Line 4. Total Number of Appeal Requests per 1,000 enrollees: **[insert # here]**

Instructions: This number is calculated by multiplying the total number of requests for an appeal (line #2) by (1,000) and dividing by the total number of enrollees as of the last date of the data collection period (line #3).

Line 5. Of the Appeal Requests Received by **[Organization Name]** between **[04/01/02** through **03/31/03]**, **[Organization Name]** completed **[insert # here]**.

Instructions: This number should be equal to or less than the number in line #2. Organizations are reporting cases received in the period indicated in line #1, but completed at the M+C organization level within 60 days following the last date in line #1. For example, a withdrawal would be reflected in line #2 as a case received; but since a decision is not rendered for a withdrawn case, a withdrawal would not be reflected in this line item.

A "completed" appeal means one that has been resolved by the M+C organization or has left the M+C organization level. If there were no withdrawals, we anticipate that the number of completed appeals will be the same as the number of requests for reconsideration, provided the M+C organization has met its deadlines.

Therefore, the organization is accounting for all appeals that it has completed within 60 days after the last date in line #1.

The 60-day timeframe is based on the maximum timeframe in 422.590(b), which allows an M+C organization 60 days to resolve a dispute involving a claim or payment either by deciding an enrollee should receive payment or by forwarding the case to the independent review entity. Cases involving requests for services have a shorter timeframe.

Of those cases:

NOTE: partial denials should be recorded as not decided fully in favor of the enrollees.

Line 6. **[Insert # here]** or **[insert % here]** of the appeals were decided fully in favor of the enrollee.

Line 7. **[Insert # here]** or **[insert % here]** of the appeals were not decided fully in favor of the enrollee.

Line 8. **[Insert # here]** or **[insert % here]** were withdrawn by the enrollee.

[**NOTE**: When the decision is not fully in favor of the enrollee, or when the decision is not completed within the required time, as specified in 42 CFR 422.590, the case is automatically sent to the independent review entity.]

Line 9. For all appeals received by **[Organization Name]** between **[04/01/02** through **3/31/03]**, **[insert # here]** cases were sent to the independent review entity for review.

Instructions: This number should be the same as the number in line #7, provided that all case files were forwarded to CHDR timely.

Of those cases:

[**NOTE**: Partial denials should be recorded as not decided fully in favor of the beneficiary.]

Line 10. **[Insert # here]** or **[insert % here]** of **[Organization's Name]** cases reviewed by the independent review entity were decided fully in favor of the enrollee.

Line 11. **[Insert # here]** or **[insert % here]** of **[Organization's Name]** cases reviewed by the independent review entity were not decided fully in favor of the enrollee.

Line 12. **[Insert # here]** or **[insert % here]** were withdrawn by the enrollee.

Line 13. **[Insert # here]** or **[insert % here]** are still awaiting a decision by the independent review entity.

In certain situations, the M+C organization is required to process an appeal faster because delay in making a decision could cause serious harm to enrollees. This is called an expedited appeal. In many cases, it is the M+C organization that decides whether or not to expedite the appeal.

Instructions: The following measurements are meant to reveal how often the M+C organization granted requests for the expedited processing of an appeal. (Expedited organization determinations are not covered by this measure.)

Line 14. Between **[04/01/02** through **03/31/03] [Organization Name]** received **[insert # here]** requests for expedited processing for appeals.

Of those cases:

Line 15. **[Insert # here]** or **[insert % here]** of the requests for expedited processing of the appeal were granted.

Instructions: This line includes cases where the decision was to expedite.

170.5.2 - Quality of Care Grievance Data

(Rev. 22, 05-09-03)

Line 1. Time Period Covered: **[Reporting Period lasts from 7/01/03 through 12/31/03, which includes data collected from 4/01/02 through 3/31/03].**

Line 2. Total number of Quality of Care Grievances Received by **[Organization's name: insert # here].**

Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period.

Line 3. Average Number of Enrollees in **[Organization's name]: [insert # here].**

Instructions: To calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by 12 (the total number of months in the data collection period).

Line 4. Total Number of Quality of Care Grievances received per 1,000 enrollees **[insert # here].**

Instructions: This number is calculated by multiplying the total number of grievances by (line #2) by (1,000) and dividing by the total number of enrollees as of the last date of the reporting period (line #3).

Instructions: This line should only include grievances that involve quality of care complaints received during the data collection period.

In addition to reporting raw data to beneficiaries, M+C organizations also must explain what the numbers mean in a separate report. See Appendix 2 for model language.

170.6 - Explaining Appeal and Quality of Care Grievance Data Reports

(Rev. 22, 05-09-03)

The model language included in Appendix 2 provides both contextual information and, where possible, offers an explanation about what the data provided by an M+C

organization might suggest to a beneficiary. By doing so, the M+C organizations will help beneficiaries to make a connection between the processing and disposition of appeals.

Line 10 of the appeal data report (see above) requires M+C organizations to report the number or percentage of cases reviewed by the independent review entity, that were decided fully in favor of an enrollee.

The report shows that of the 86 appeal cases that XYZ Organization forwarded to the independent review entity for review (see line 9), 16 or 19 percent were decided fully in favor of an enrollee. On page 4 of Appendix 2, the report provides background regarding independent reviews. For example, one sentence states that an independent review provides an opportunity for a new, fresh look at the appeal outside of the plan. Also, in an effort to explain why the independent review entity might disagree with XYZ organization, the report offers that the independent review entity may have had more information about the appeal.

If M+C organizations format their reports according to Appendix 2, M+C organizations will meet the disclosure requirements set forth in the M+C regulations at 42 CFR 422.111(c)(3). You may use the model reports or develop your own; however, you must include the content of every line item from above. If you develop your own report, you must only include factual information and you must avoid including subjective statements such as “this is a low number of appeals for an M+C organization.” In addition, all reports must be approved by your CMS Regional Office (RO) plan manager. National plan's language will be approved by the lead RO in accordance with CMS' marketing guidelines. While the CMS RO approves the content of the report, the M+C organization is solely responsible for the validity of the data included in the report.

Appendix 1 - Notice of Denial of Medical Coverage and Notice of Denial of Payment

(Rev. 22, 05-09-03)

The form, Notice of Denial of Medical Coverage - Form CMS-10003-NDMC, and Instructions for Form CMS-10003-NDMC can be found on CMS' Forms Page.

The form, Notice of Denial of Payment - Form CMS-10003-NDP, and Instructions for Form CMS-10003-NDP can be found on CMS' Forms Page.

Appendix 2 - Beneficiary Appeals and Quality of Care Grievances Explanatory Data Report

(Rev. 22, 05-09-03)

MEDICARE APPEALS AND QUALITY OF CARE GRIEVANCES XYZ ORGANIZATION April 1, 2002 to March 31, 2003

What kind of information is this?

When you ask for it, the government requires (**XYZ Organization**) to provide you with reports that describe **what happened** to formal complaints that (**XYZ Organization**) received from their Medicare members. There are two types of formal complaints: **Appeals and Grievances. Medicare members have the right to file an appeal or grievance with their Medicare health plans**. The next few pages contain information about the appeals and quality of care grievances that (**XYZ Organization**) received between April 1, 2002, and March 31, 2003.

Each Medicare health plan will have different numbers of appeals and quality of care grievances, and these numbers can mean different things. For example, a Medicare health plan might have a small number of appeals and quality of care grievances because the plan talks with members about their concerns and agrees to find solutions. Or a Medicare health plan might have a small number of appeals and quality of care grievances because its members are not aware of their right to file an appeal or grievance.

How big is (XYZ Organization)?

(**XYZ Organization**) has about 88,000 Medicare members.

(line 3 on the attached report)

Appeals Information beginning on Page 2
Quality of Care Grievance Information on Page 6

INFORMATION ON MEDICARE APPEALS

April 1, 2002 To March 31, 2003

What is an appeal?	An appeal is a formal complaint about (**XYZ Organization**)'s decision not to pay for, not to provide, or to stop an item or service that a Medicare member believes s/he needs. If a member cannot get an item or service that the member feels she/he needs, or if the health plan has denied payment of a claim for a service the member has already received, the member can appeal. For example, a member might appeal (**XYZ Organization**)'s decision to stop physical therapy, to deny a visit to a specialist, or to deny payment of a claim
How many appeals did (XYZ Organization) receive?	(**XYZ Organization**) received 174 appeals from its Medicare members. About 2 out of every 1,000 Medicare members appealed (**XYZ Organization**)'s decision not to pay for or provide, or to stop a service that they believed they needed. (lines 2 and 4 on the attached report)
How many appeals did (XYZ Organization) review?	(**XYZ Organization**) reviewed 157 appeals during this time period. (lines 5 through 8 on the attached report)
What happened?	From the **174** appeals it received from its members: (**XYZ Organization**) decided to pay for or to provide all services that the member asked for **41%** of the time. (**XYZ Organization**) decided **not** to pay for or to provide the services that the member asked for **49%** of the time. Medicare members withdrew their request before (**XYZ Organization**) could decide **10%** of the time.

INFORMATION ON EXPEDITED OR "FAST" APPEALS

April 1, 2002 to March 31, 2003

What is a "fast" or expedited appeal?	A Medicare member can request that (**XYZ Organization)** review the member's appeal quickly if the member believes that his health could be seriously harmed by waiting for a decision about a service. This is called a request for an **expedited** or **"fast" appeal.**
	(**XYZ Organization**) looks at each request and decides whether a "fast" appeal is necessary. By law, (**XYZ Organization**) must consider an appeal as quickly as a member's health requires. If (**XYZ Organization**) determines that a "fast" appeal is necessary, it must notify the Medicare member as quickly as the member's health requires but no later than 72 hours
How many "fast" appeals did XYZ Organization receive?	(**XYZ Organization**) received **20** requests for "fast" appeal from its Medicare members. (lines 14 through 16 on the attached report)
What happened?	When a member requested a "fast" review, (**XYZ Organization**) agreed that a "fast" review was needed **75%** of the time.
	(**XYZ Organization**) did not agree to a "fast" review **25%** of the time. This number may include requests by members for whom the health plan may not have believed were in danger or serious harm.

INFORMATION ON INDEPENDENT REVIEW

April 1, 2002 to March 31, 2003

What is Independent Review of an appeal?

After a member has sent an appeal to (**XYZ Organization**), if the organization continues to decide that it should not pay for or provide all services that the member asked for, (**XYZ Organization**) must send all of the information about the appeal to an **independent review organization** that contracts with Medicare, not for (**XYZ Organization**).

An independent review provides an opportunity for a new, fresh look at the appeal outside of the health plan. The independent review organization goes over all of the information from (**XYZ Organization**) and can consider any new information.

If the independent review organization does not agree with (**XYZ Organization**)'s decision, (**XYZ Organization**) must provide or pay for the services that the Medicare member requested.

There may be several reasons why the independent review organization decides to agree with either the Medicare member or (**XYZ Organization**). For example, the independent review organization may disagree with (**XYZ Organization**) because the independent review organization may have had more information about the appeal.

Independent Review Continued on Page 5

INFORMATION ON INDEPENDENT REVIEW

April 1, 2002 to March 31, 2003

How many appeals did the independent review organization consider?	The independent review organization considered **86** appeals from (**XYZ Organization**). (lines 9 through 13 on the attached report)
What happened?	The independent review organization agreed with the Medicare member's appeal **19%** of the time. This means that in **19%** of these cases, (**XYZ Organization**) ended up paying for or providing all services that these members asked for. The independent review organization disagreed with the Medicare member's appeal **70%** of the time. This means that in **70%** of these cases, (**XYZ Organization**) ended up **not** paying for or providing all services that these members asked for. Medicare members withdrew their request for independent review **9%** of the time. By June 01, 2003, **2%** of appeals were still waiting to be reviewed by the independent review organization. Note that these percentages may not add to 100% because sometimes the independent review organization dismisses an appeal.

INFORMATION ON QUALITY OF CARE GRIEVANCES

April 1, 2002 to March 31, 2003

What is a quality of care grievance?

A grievance is a complaint that a Medicare member makes about the way (**XYZ Organization**) provides care (other than complaints about requests for service or payment). A **grievance** about the **quality of care** is one kind of grievance. For example, a member can file a grievance about the quality of care when the member believes that the service the member received was not timely or correct, when the member had problems getting a service because of long waiting times or long travel distances, or when the wrong kind of doctor or hospital provided the service.

How many quality of care grievances did (XYZ Organization) receive?

(**XYZ Organization**) received **20** grievances about the quality of care. About **less than 1 out of every 1,000** Medicare members filed a grievance about the quality of care they received from (**XYZ Organization**) doctors and hospitals.

(lines 2 and 4 under "Quality of Care Grievance Data" on the attached report)

Where can I get more information?

If you are a member of (**XYZ Organization**), you have the right to file an appeal or grievance.

You can contact (**XYZ Organization**) at (###) ###-#### to resolve a concern you may have or to get more information on how to file an appeal or grievance. (Be sure to include a phone number for the hearing impaired and your hours of operation.) You may also refer to your Evidence of Coverage for a complete explanation of your rights.

You also can contact a group of independent doctors in **STATE**, called a Quality Improvement Organization, at (###) ###-#### for more information about quality of care grievances or to file a quality of care grievance.

Appendix 3 - Notice of Discharge and Medicare Appeal Rights

(Rev. 22, 05-09-03)

NOTICE OF DISCHARGE & MEDICARE APPEAL RIGHTS

Enrollee's Name:	Date of Notice:
Health Insurance Claim (HIC) Number:	Admission Date:
Attending Physician:	Discharge Date:
Hospital:	Health Plan:

YOUR IMMEDIATE ATTENTION IS REQUIRED

Your doctor has reviewed your medical condition and has determined that you can be discharged from the Hospital because: [check one]

_____You no longer require inpatient hospital care.

_____You can safely get any medical care you need in another setting.

_____Other_____.

[Fill in details.]

This also means that, if you stay in the hospital, it is likely that your hospital charges for [**specify date of first noncovered day**], and thereafter will not be covered by your Health Plan.

The Hospital has developed a discharge plan which explains any follow-up care or medications you need. If you have questions about this follow-up care, you should discuss them with your doctor. If you have not received a discharge plan and wish to do so, please contact your nurse, social worker or doctor.

If you agree with your doctor's discharge decision, you can either read further to learn more about your appeal rights, or you can skip to the end of this notice and sign to show that you have received this notice.

However, if you disagree with your Doctor's discharge decision, Medicare gives you the right to appeal. In that case, please continue reading to learn how to appeal a discharge decision, what happens when you appeal, and how much money you may owe.

IF YOU THINK YOU'RE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON, REQUEST AN IMMEDIATE REVIEW

HOW DO YOU GET AN IMMEDIATE REVIEW?

1. The [**Name of QIO**] is the name of the Quality Improvement Organization - sometimes called a QIO - authorized by Medicare to review the Hospital care provided to Medicare patients. You or your authorized representative, attorney, or court appointed guardian must contact the QIO by telephone or in writing: [**Name, address, telephone and fax number of the QIO**]. If you file a written request, please write, "I want an immediate review".

2. Your request must be made no later than noon of the first working day after you receive this notice.

3. The QIO will make a decision within one full working day after it receives your request, your medical records, and any other information it needs to make a decision.

4. While you remain in the Hospital, your Health Plan will continue to be responsible for paying the costs of your stay until noon of the calendar day following the day the QIO notifies you of its official Medicare coverage decision.

WHAT IF THE QIO AGREES WITH YOUR DOCTOR'S DISCHARGE DECISION?

If the QIO agrees, you will be responsible for paying the cost of your Hospital stay beginning at noon of the calendar day following the day the QIO notifies you of its Medicare coverage decision.

WHAT IF THE QIO DISAGREES WITH YOUR DOCTOR'S DISCHARGE DECISION?

You will not be responsible for paying the cost of your additional Hospital days, except for certain convenience services or items not covered by your Health Plan.

WHAT IF YOU DON'T REQUEST AN IMMEDIATE REVIEW?

If you remain in the Hospital and do not request an immediate review by the QIO, you may be financially responsible for the cost of many of the services you receive beginning [specify date of first noncovered day].

If you leave before [specify date of first noncovered day], you will not be responsible for the cost of care. As with all hospitalizations, you may have to pay for certain convenience services or items not covered by your Health Plan.

WHAT IF YOU ARE LATE OR MISS THE DEADLINE TO FILE FOR AN IMMEDIATE REVIEW?

If you are late or miss the noon deadline to file for an immediate review by your QIO, you may still request an expedited (fast) appeal from your Health Plan. A "fast" appeal means your Health Plan will have to review your request within 72 hours. However, you will not have automatic financial protection during the course of your appeal. This means you could be responsible for paying the costs of your Hospital stay beginning [specify date of first noncovered day].

HOW DO YOU REQUEST A FAST APPEAL?

You may call or fax your request to your Health Plan:

Stamp or Print Here
Name of Health Plan
Address
Phone # and Fax #

If you filed a request for immediate QIO review but were late in filing the request, the QIO will forward your request to your Health Plan as a request for a fast appeal.

If you're filing a written request, please write, "I want a fast appeal."

If you or any doctor asks your Health Plan to give you a fast appeal, your Health Plan must process your appeal within 72 hours of your request.

Your Health Plan may take up to 14 extra calendar days to make a decision if you request an extension or if your Health Plan can justify how the extra days will benefit you. For example, you should request an extension if you believe that you or your Health Plan need more time to gather additional medical information. Keep in mind that you may end up paying for this extended hospital stay.

Please sign to let us know you have received this notice of discharge and appeal rights. By signing this notice, you do not give up your right to appeal this discharge.

_____

Signature of Medicare Enrollee or Authorized Representative Date

cc: [**Health Plan**]

Appendix 4 - Appointment of Representative - Form CMS-1696-U4

(Rev. 22, 05-09-03)

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME (Print or Type)	H.I. CLAIM NUMBER

SECTION I APPOINTMENT OF REPRESENTATIVE

I appoint this individual:_____
(Print or type name and address of individual you want to represent you)

to act as my representative in connection with my claim or asserted right under Titles XI, or XVIII of the Social Security Act. I authorize this individual to make or give any request or notice; to present or to elicit evidence; to obtain information; and to receive any notice in connection with my claim wholly in my stead.

SIGNATURE (Beneficiary)	ADDRESS
TELEPHONE NUMBER (Area Code)	DATE

SECTION II ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration or the Centers for Medicare & Medicaid Services; that I am not, as a current or former officer or employee of the United States, disqualified from acting as the claimant's representative; and that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations referred to on the reverse side hereof. In the event that I decide not to charge or collect a fee for the representation I will notify the Social Security Administration and the Centers for Medicare & Medicaid Services (completion of Section III (optional) satisfies this requirement).

I am a / an _____
(Attorney, union representative, relative, law student, etc.)

SIGNATURE (Representative)	ADDRESS
TELEPHONE NUMBER (Area Code)	DATE

SECTION III (Optional) WAIVER OF FEE OR DIRECT PAYMENT

(Note to Representative: You may use this portion of the form to waive a fee or to waive direct payment of the fee from withheld past-due benefits.)

I waive my right to charge and collect a fee for representing _____ _____ before the Social Security Administration or the Centers for Medicare & Medicaid Services.

SIGNATURE	DATE

(See important information on reverse)
FORM CMS-1696-U4 (10-84)

Appendix 5 - Appointment of Representative - Form SSA-1696-U4

(Rev. 22, 05-09-03)

Social Security Administration
Please read the back of the last copy before you complete this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part I **APPOINTMENT OF REPRESENTATIVE**

I appoint this person, _____,
(Name and Address)
to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title IV FMSHA (Black Lung) ☐ Title XVIII (Medicare Coverage)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I am appointing, or I now have, more than one representative. My main representative is _____.
(Name of Principal Representative)

Signature (Claimant)	Address
Telephone Number (with Area Code) ( )	Date

Part II **ACCEPTANCE OF APPOINTMENT**

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

☐ I am an attorney. ☐ I am not an attorney. (Check one.)

Signature (Representative)	Address
Telephone Number (with Area Code) ( )	Date

Part III (Optional) **WAIVER OF FEE**

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date

Part IV (Optional) **ATTORNEY'S WAIVER OF DIRECT PAYMENT**

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney Representative)	Date

Form SSA-1696-U4 (4-95) (See Important Information on Reverse) FILE COPY
Use Until Stock Is Exhausted

Appendix 6 - Waiver of Liability Statement

(Rev. 22, 05-09-03)

WAIVER OF LIABILITY STATEMENT

_____

Medicare/HIC Number

_____

Enrollee's Name

_____ _____

Provider Dates of Service

_____

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

_____ _____

Signature Date

Appendix 7 - Enrollee Rights

(Rev. 22, 05-09-03)

Organization Policies (QISMC standard 2.1)

The organization implements written policies with respect to the enrollee rights specified in standard 2.2.

The organization must articulate enrollees' rights, promote the exercise of those rights, and ensure that its staff and affiliated providers are familiar with enrollee rights and treat enrollees accordingly. While most of the standards in this domain address basic procedural protections for enrollees, they are closely related to quality of care. Interpersonal aspects of care are highly important to most patients. Enrollees' interactions with the organization and its providers can have an important bearing on their willingness and ability to understand and comply with recommended treatments, and hence on outcomes and costs. For further technical assistance with this domain, readers are directed to the Consumer Bill of Rights and Responsibilities as promulgated in November 1997 by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

2.1.1.1 - Policies are communicated to enrollees, in the enrollee statement furnished in accordance with standard 2.3, and to the organization's staff and affiliated providers, at the time of initial employment or affiliation and annually thereafter.

Material on enrollee rights must be included in provider contracts or provider manuals and in staff handbooks or other training materials.

2.1.1.2 - The organization monitors and promotes compliance with the policies by the organization's staff and affiliated providers.

The organization should monitor compliance through analysis of complaints or grievances, requests to change providers, enrollee satisfaction surveys, rapid disenrollment surveys, and other sources of enrollee input. Issues in compliance should be addressed through education or counseling of the staff or providers or other corrective action, and information on compliance with the policies should be considered during the recredentialing and staff evaluation process and within the QAPI program.

2.1.2 - The organization ensures compliance with Federal and State laws affecting the rights of enrollees.

Applicable Federal laws include, but are not limited to:

1. Title VI of the Civil Rights Act;

2. Section 504 of the Rehabilitation Act of 1973;

3. The Age Discrimination Act of 1975;

4. Titles II and III of the Americans with Disabilities Act;

5. Section 542 of the Public Health Service Act (pertaining to nondiscrimination against substance abusers); and

6. Title 45, Part 46 of the Code of Federal Regulations, pertaining to research involving human subjects.

In general, these laws are enforced by agencies other than CMS or the State Medicaid Agency, and reviews conducted under these standards will not include detailed assessment of an organization's compliance. However, CMS or States will report any observed violations and refer any enrollee complaints to the appropriate agency for resolution.

The organization must include provisions relating to compliance with Federal and state laws in subcontracts with providers. Assessment of compliance should be included in the organization's credentialing procedures to the extent feasible and appropriate; for example, if site visits to individual providers' offices are conducted, they should include a general assessment of physical accessibility. Compliance issues identified may be addressed through the organization's QAPI program.

2.2 - Specification of Rights. Each enrollee has a right:

2.2.1.1 - The organization implements procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

The organization's confidentiality procedures should apply not just to medical records, but to any information in the possession of the organization or its contractors that could disclose medical conditions or the use of specific services, such as claims information or information collected in the course of QAPI, utilization or case management, or other processes. Procedures must address both written materials and information created in other formats, such as electronic records, facsimiles, or electronic mail. The organization's procedures should protect against unauthorized or inadvertent disclosure of information to any individual, including the organization's own employees or contractors, who does not have an identifiable need for the information. In addition, procedures should assure that no individual retains information after putting it to use for the purpose for which it was obtained.

The organization's confidentiality protections must extend to minors. The organization must have policies that, consistent with state and Federal law, define whether and under what circumstances treatment may be furnished to a minor without parental consent and what information will be released to a parent on request. Specific issues to be addressed should include family planning, other reproductive health services, and mental health or substance abuse services.

An organization with Medicaid enrollees must have specific procedures to ensure that information on enrollees' Medicaid eligibility status is released only when necessary (for example, when a provider must be able to identify Medicaid beneficiaries who are exempt from copayment requirements) and that recipients of this information in turn agree to maintain confidentiality.

2.2.1.1.1 - The right to privacy includes protection of any information that identifies a particular enrollee. Information from, or copies of, records may be released only to authorized individuals, and the organization must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Federal or state laws, court orders, or subpoenas.

This standard pertains to the release of information to third parties and is not meant to impede the exchange of information among the organization, its affiliated providers, and other contractors as necessary to carry out the organization's contractual responsibilities.

When a state's managed care program (e.g., by "carving out" certain services such as mental health care) or an enrollee's dual coverage by both Medicaid and Medicare creates a situation in which a Medicare or Medicaid beneficiary is enrolled in more than one managed care organization, all such Medicaid and Medicare managed care organizations in which beneficiaries are enrolled are not considered "third parties" for purposes of this standard. Individual, identifiable personal information pertaining to such enrollees' health and health care may be released, to the extent allowed under state and Federal law, without the prior consent of the beneficiary, to any other Medicare or Medicaid managed care organization so as to ensure continuity and coordination of care.

2.2.4.1 - The organization provides for the enrollee's representative to facilitate care or treatment decisions when the enrollee is unable to do so.

Written policies and procedures address the care and treatment of enrollees who are unable to exercise rational judgment or give informed consent. State law will generally govern who may act as an enrollee's representative. A representative may be (1) A person who is designated as the enrollee's representative (e.g., by a power of attorney); (2) A court appointed guardian; (3) A spouse or other family member as designated by the enrollee; or (4) Another person designated by a state agency.

2.2.6 - To have access to his or her medical records in accordance with applicable Federal and state laws; and

The organization must have procedures through which an enrollee can obtain timely access to all medical records and health information maintained by the organization, including records maintained by subcontracting providers from whom the enrollee has received services.

2.3 - Enrollee Information

Enrollee understanding of the workings of the organization, procedures for obtaining services, and rights and responsibilities, are essential to the provision of quality care. This standard measures the comprehensiveness of the content of enrollee information and the accessibility of this information. Review of compliance with this standard is part of a broader review of the organization's basic information for enrollees. This standard addresses only those elements of enrollee information that are directly related to the use of health services. (Guidelines are provided below only for those individual elements that are not self-explanatory.) Note that information required to be furnished to enrollees must also be made available to any representative designated by or on behalf of the enrollee.

2.3.1 - Each enrollee receives, at the time of enrollment and at least annually thereafter, a written statement including information on:

2.3.1.1 - Enrollee rights;

2.3.1.2 - Enrollee responsibilities;

While it is advisable to include a discussion of enrollee responsibilities in enrollee information, the discussion should clearly indicate that enrollment and subsequent receipt of care is not conditional on the enrollee's agreement to follow a particular course of prescribed treatment.

2.3.1.9 - Charges to enrollees, if applicable;

2.3.1.10 - Procedures established under standard 2.4 for resolving enrollee issues, including complaints or grievances and issues relating to authorization of, coverage of, or payment for services;

2.3.1.14.3 The number of grievances and appeals and their disposition in the aggregate, in a manner and form specified by CMS (for Medicare) and the State Medicaid Agency (for Medicaid).

2.3.3 - Enrollee information is:

2.3.3.1 - Readable and easily understood;

Generally materials should be understandable to enrollees at a fifth-grade reading level. Materials should use an easily readable typeface and frequent headings, and should provide short, simple explanations of key concepts. Technical or legal language should be avoided whenever possible.

2.3.3.2 - Available in the language(s) of the major population groups served and, as needed, in alternative formats for the visually impaired.

The organization must have a procedure for ascertaining the primary language of enrollees and for making information materials available in any language that is the primary language of more than 10 percent of the geographic area.

2.4 - Resolution of Enrollee Issues. The organization has a system for resolving issues raised by enrollees, including: Complaints or grievances; issues relating to authorization of, coverage of, or payment for services; and issues relating to discontinuation of a service. [NOTE: References to an enrollee in these standards include reference to an enrollee's representative.]

Medicare and State Medicaid programs use a variety of terms for circumstances in which an enrollee voices a concern with, or requests an action by, the organization. Different processes, both for the organization and for CMS or the State Medicaid Agency, govern the resolution of different types of issues raised by enrollees. This standard presents a unified structure for evaluating the organization's performance in carrying out those elements of each process for which it is responsible.

The standard distinguishes among three basic categories of enrollee issues:

1. **Initial requests that the organization or its subcontractor provide or authorize a service or pay for a service already obtained.**

   This category includes requests made directly to a provider, requests made by an enrollee or a provider through an organization's system for prior approval of services, and requests in the form of claims for payment filed by the enrollee or a provider. Any such request results in an initial decision by the organization (or by a provider to whom the initial decision-making authority has been delegated) to approve or disapprove provision of or payment for the service. Under Medicare, this decision is known as an "organization determination." Under Medicaid, an initial decision to deny, reduce or terminate a service or to deny payment or to not furnish a service with reasonable promptness is known as an "action."

2. **Requests that the organization, its subcontractor, or a government agency reconsider a decision not to provide or authorize a service or pay for a service already obtained.**

   When an organization or its subcontractor makes an initial decision ("organization determination" or "action") not to provide or pay for a covered service (or a service that is perceived by the enrollee as covered), the enrollee is entitled to reconsideration under Medicare. This is true both of determinations that a requested service is not covered under the Medicare contract and of decisions that a covered service is not necessary or appropriate for the particular enrollee.

   Under Medicare, a request for reconsideration is initially reviewed by the organization. If the organization does not make a "fully favorable" determination

- that is, agree to provide or pay for the service in whole - the request is forwarded to the "reconsideration contractor," (an entity under contract to CMS to resolve coverage disputes), and may be subject to further levels of administrative or judicial review. This process applies for basic services (services covered under the Medicare statute for all beneficiaries), "mandatory" supplemental services (services covered under a package that all Medicare enrollees must purchase as a condition of enrolling in the organization under its Medicare contract), and (as established by the BBA) optional supplemental benefits (non-Medicare services covered under a supplemental benefit package that each Medicare enrollee may choose whether or not to purchase). Standard 2.4.3 addresses the process of reconsideration by the organization itself and does not address the subsequent steps in the process.

3. Complaints or grievances on all other matters.

In Medicare, enrollee concerns on all issues not involving a request for provision of or payment for a service are treated as grievances and are subject to the procedures established under standard 2.4.2. This is not the case in Medicaid, because requests for provision of or payment for a service are considered complaints or grievances and are subject to the procedures established under 2.4.2. This standard does not distinguish between "formal" and "informal" grievances, or between "grievances" and "complaints." For the purpose of these standards a grievance is defined as:

Any communication, oral or written, from an enrollee to any employee of the organization or of its providers, expressing dissatisfaction with any aspect of the organization's or provider's operations, activities, or behavior, regardless of whether any remedial action is requested.

Examples of possible subjects of grievances include, but are not limited to, complaints about:

- The quality of services provided (other than a refusal to furnish a requested service);
- Interpersonal aspects of care, such as rudeness by a provider or staff member; or
- Failure to respect any of the enrollee's rights, as set forth in standard 2.2.

Under both Medicare and Medicaid, certain issues relating to disenrollment of an enrollee may also be considered through the organization's grievance process. Medicare requires that an organization seeking the involuntary disenrollment of an enrollee for cause must allow the enrollee to contest the organization's decision through the grievance process.

2.4.1 - Intake of Enrollee Issues. The organization follows written procedures for the receipt and initial processing of all issues raised by enrollees.

The organization has received an issue when the enrollee directs any oral or written communication about the issue to any employee of the organization or its contracting providers, or when an enrollee concern is forwarded to the organization by another entity (for example, when a Social Security or Railroad Retirement office transmits a complaint made by a Medicare beneficiary). It is therefore essential that all personnel who may come into contact with enrollees understand the basic procedures for receiving and recording an issue and for initiating the applicable process for resolving the issue.

2.4.1.1 - Documents each issue raised by an enrollee;

When an enrollee raises an issue, the enrollee must immediately be informed of whether the issue is: (a) One that the enrollee must present to the organization in writing or (b) One that the enrollee may present orally and that will be recorded by the person receiving the issue. Requests for a service or payment, or for reconsideration of an initial decision to deny a service or payment request, should be presented by the enrollee in writing. However, in the case of expedited reviews, oral requests are permitted. In Medicaid, grievances may be presented orally, although the enrollee must always be notified that he or she has the right to present a written grievance. If the person receiving the issue is uncertain of what category it falls into, the issue must be presented by the enrollee in writing.

There may be instances in which an enrollee expresses a concern orally to staff of the organization or an affiliated provider, and the issue is resolved to the enrollee's satisfaction immediately and informally. Nevertheless, the issue and its resolution must be recorded, through a complaint log or other means, so that information on volume and nature of enrollee issues is available in the Quality Assessment and Performance Improvement (QAPI) process and for other management functions.

2.4.1.2 - Promptly determines whether the issue is to be resolved through: (a) The grievance process established under standard 2.4.2, (b) The process for making initial determinations on coverage and payment issues established under standard 3.3, or (c) The process for resolution of disputed initial determinations established under standard 2.4.3;

Except in the case of grievances that are immediately resolved to the enrollee's satisfaction, the person receiving the enrollee issue must determine what type of issue it is and how it will be resolved (or must promptly forward the issue to personnel authorized to make this determination). This exception does not apply to Medicaid.

2.4.1.3 - Acknowledges receipt of the issue and explains to the enrollee the process to be followed in resolving his or her issue;

As soon as the organization has made the determination required under standard 2.4.1.2, the enrollee must receive an acknowledgment that the issue has been recorded and a clear

explanation of how it will be resolved, describing each step in the process, the timeframe for each step, and the enrollee's rights or responsibilities at each step. In the case of grievances, acknowledgment of receipt and explanation of the process may be made orally; however, grievances relating to quality of care issues must be acknowledged in writing, and the acknowledgment must specifically describe the issue raised by the enrollee.

2.4.1.4 - Assists the enrollee as needed in completing forms or taking other necessary steps to obtain resolution of the issue; and

2.4.1.5 - Informs the enrollee of any applicable mechanism for resolving the issue external to the organization's own processes.

The enrollee must be notified of alternative routes for resolution of his or her issue. Under Medicare, for example, an enrollee has a right to submit a quality of care complaint for investigation by the Quality Independent Organization (QIO), instead of pursuing it through the organization's grievance process. Under Medicaid, coverage and payment issues may be presented to the State Agency at any time. In addition, some states may have issue resolution mechanisms that are available to commercial enrollees of organizations as well as to Medicare and Medicaid enrollees, such as a hotline or other complaints system maintained by the Insurance Commissioner or another state agency. (Such a system would supplement, but not replace, the State Medicaid Agency's own hearing process.)

2.4.2 - Grievances. The organization implements a procedure, with clearly explained steps and time limits for each step, for the resolution of a complaint or grievance.

2.4.2.1 - The grievance is transmitted in a timely manner to staff who have authority to take corrective action. A grievance relating to quality of care is transmitted to appropriately qualified clinical personnel.

2.4.2.2 The organization investigates the grievance and notifies the concerned parties of the results of the investigation and the proposed resolution.

The resolution must directly address the issue raised in the grievance, and the proposed solution must be appropriate to the seriousness of the complaint.

2.4.2.3 - The organization provides an opportunity for reconsideration of the proposed resolution.

When the enrollee is not satisfied with the proposed resolution of a grievance, there must be an opportunity for further consideration by an individual or individuals other than the individual who initially reviewed the grievance.

2.4.2.4 - The organization tracks each grievance until its final resolution.

The organization must have a system for monitoring its progress in reviewing and resolving each grievance, to assure that each step is completed within the timeframe specified in the organization's grievance procedures.

2.4.2.5 - The organization has an expedited grievance process for issues requiring immediate resolution.

Under Medicare, however, there may be issues that are treated as grievances and are therefore not subject to this process, but that may nevertheless require rapid response. This would be true, for example, when an enrollee reports that he or she is unable to obtain a timely appointment from a primary care provider for a problem in need of immediate attention. Thus an expedited grievance process is required in all organizations, regardless of the applicable procedure for obtaining reconsideration of denials of service.

2.4.3 - Reconsideration of Coverage and Payment Determinations. The organization implements a procedure, with clearly explained steps and time limits for each step, for reviewing requests for reconsideration of initial decisions not to provide or pay for a service.

As noted earlier, this standard applies to all Medicaid actions and to Medicare reconsiderations related to basic or mandatory or optional supplemental services.

2.4.3.1 - The organization's notice to an enrollee and/or provider of its decision to deny, limit, or discontinue authorization of, or payment for, a service includes information required under standard 3.3.1.5, including information about how to obtain a reconsideration of the decision. The notice to the enrollee must be in writing.

When a service request is made directly to a provider and the provider denies the request orally, the organization/provider must provide written notice to the enrollee of the right to obtain reconsideration and the procedure for requesting reconsideration.

2.4.3.2 - The organization's process complies with procedural requirements and time limits established by CMS (for Medicare) or the State Medicaid Agency (for Medicaid), conforming with CMS requirements.

Medicare regulations specify procedural time limits for service and payment determinations.

2.4.3.3 - Requests for reconsideration by the organization of a denial based on lack of medical necessity are reviewed by a physician (for Medicare) or health care professional (for Medicaid) who is appropriately credentialed with respect to the treatment involved and who is not the individual who made the initial determination.

Both the physician (for Medicare) and the health care professional (for Medicaid) must be appropriately credentialed. If the organization delegates any phase of the reconsideration process to a subcontractor, the subcontractor must have its own procedures for complying with this standard. This standard means that the reconsideration function may not be delegated to a single provider.

2.4.4 - Monitoring of Issue Resolution Processes. The organization maintains, aggregates, and analyzes information on the nature of issues raised by enrollees and on their resolution.

2.4.4.1 - The information is used to develop activities under the organization's QAPI program, both to improve the issue resolution process itself, and to make improvements that address other system issues raised in the issue resolution process.

2.4.4.2 - Information related to coverage and payment issues is maintained for at least three years following final resolution of the issue, and is made available to the enrollee on request.